VA National Formulary

VISN 20

Formulary Status: Formulary

Sort Order: Generic Name

Formulary by Class | Formulary by Generic Name | Non-formulary by Class | Non-formulary by Generic Name

VA Class	Generic Name	Brand Name	Restriction Text	Formulary Status
DE350	A & D OINT (OTC)	VITAMIN A AND D	Open Formulary - no restrictions	FORMULARY
AM800	ABACAVIR 300MG TAB	ZIAGEN	Restricted to HIV prescribers	FORMULARY
AM800	ABACAVIR 300MG/LAMIVUDINE 150MG/ZIDOVUDINE 300MG COMB TAB	TRIZIVIR	Restricted to HIV prescribers	FORMULARY
AM800	ABACAVIR ORAL SOLN	ZIAGEN	Restricted to HIV prescribers	FORMULARY
AM800	ABACAVIR/LAMIVUDINE ORAL	EPZICOM	Restricted to HIV prescribers and Infectious Disease Service or local equivalent(s).	FORMULARY
BL700	ABCIXIMAB INJ 2MG/ML 5ML	REOPRO	Restrictions per local facility	FORMULARY
HS502	ACARBOSE ORAL TAB	PRECOSE	Open Formulary - no restrictions	FORMULARY
CN101	ACETAMINOPHEN 300MG/CODEINE 30MG TAB	TYLENOL #3	Open Formulary - no restrictions	FORMULARY
CN103	ACETAMINOPHEN 325MG TAB	TYLENOL	Open Formulary - no restrictions	FORMULARY
CN103	ACETAMINOPHEN 325MG/BUTALBITAL 50MG/CAFFEINE 40MG ORAL	FIORICET	Open Formulary - no restrictions	FORMULARY
CN103	ACETAMINOPHEN ELIXIR 160MG/5ML	TYLENOL	Open Formulary - no restrictions	FORMULARY
CN103	ACETAMINOPHEN SUPP 650MG	TYLENOL	Open Formulary - no restrictions	FORMULARY
CV703	ACETAZOLAMIDE 250MG REGULAR RELEASE TAB	DIAMOX	Open Formulary - no restrictions	FORMULARY
CV703	ACETAZOLAMIDE INJ 500MG	DIAMOX	Acetazolamide sustained action (SA) tablets and capsules are non-formulary, second-line to regular release tablets. June 2008 VISN 20 P&T Commitee	FORMULARY
OP109	ACETIC ACID 2%/AL ACETATE 0.79% OTIC SOLN	DOMEBORO OTIC SOLUTION	Open Formulary - no restrictions	FORMULARY
IR100	ACETIC ACID IRRIGATION SOLN	N/A	Open Formulary - no restrictions	FORMULARY
OT109	ACETIC ACID/ALUMINUM ACETATE OTIC SOLN	DOMEBORO OTIC SOLN	Open Formulary - no restrictions	FORMULARY
OP102	ACETYLCHOLINE CL OPH SOLN	MIOCHOL	Open Formulary - no restrictions	FORMULARY
RE400	ACETYLCYSTEINE INHL SOLN	MUCOMYST	Open Formulary - no restrictions	FORMULARY
AD000	ACETYLCYSTEINE INJ 1GM/5ML	ACETADOSE	Acetylcysteine IV is restricted to the treatment of known or suspected acetaminophen overdose. 7/2004	FORMULARY
RE400	ACETYLCYSTEINE INJ 20% 30ML	MUCOMYST	Restrictions per local facility	FORMULARY
DE801	ACITRETIN ORAL	SORIATANE	National VA Criteria for Use (The response to ALL items below must be YES to use acitretin.) - Provider authorizing the initiation of therapy is a	FORMULARY

			dermatologist. Subsequent prescriptions may be renewed by dermatologists or other locally authorized clinicians (including derm residents and nurse practitioners or physician assistants working in Derm clinic. Approved clinicians should be under the supervision of or, in a co-managed care situation, working with a dermatologist, and appropriate patient monitoring must be followed. - Patient has chronic severe psoriasis Criteria for severe psoriasis Disease is disabling or impairs the patient's quality of life (self-reported), including ability to work and activities of daily living AND - Disease is extensive or does not have a satisfactory response to topical agents AND - The patient is willing to accept life-altering adverse effects to achieve less disease or no disease AND - Either description below pertains to patient: - Generally more than 10% of body surface area is involved with disease - Other factors apply (patient's attitude about disease; location of disease [e.g., face, hands, fingernails, feet, genitals]; symptoms [e.g., pain, tightness, bleeding, or severe itching]; arthralgias or arthritis). - Patient has been counseled to avoid donating blood during therapy and for at least 3 years after discontinuing therapy - If patient is a female of childbearing potential , she meets ALL three of the following requirements: - Two negative urine or serum pregnancy tests (PGTs,with a sensitivity of at least 25 mIU / ml). The first PGT should be done when a trial of acitretin therapy is first decided for the patient and the second / confirmatory PGT must be done within the first 5 d of the menstrual period immediately before starting therapy, or at least 11 d after last	

			unprotected sexual intercourse), and has negative monthly pregnancy tests during therapy. - Patient has selected and committed to use 2 effective forms of contraception simultaneously, unless absolute abstinence is the chosen method, or the patient has undergone a hysterectomy, or is clearly postmenopausal. The microdose progestin minipill is not recommended because acitretin interferes with its contraceptive effect. - Patient has agreed to use the 2 chosen effective forms of contraception simultaneously for at least 1 month prior to initiation of acitretin therapy, during therapy, and for at least 3 years after discontinuing acitretin therapy. - If patient is a female of childbearing potential, she has been counseled to avoid drinking alcohol during therapy and for 2 months following discontinuation of therapy (because of formation of etretinate, which has a long half-life of 120 days). - If patient is a female of childbearing potential, patient has been counseled to avoid taking St. John's Wort and avoid starting any new medications without first consulting a physician or pharmacist (because of a potential risk that these medications may interfere with hormonal contraceptives) - If female, patient has signed an Acitretin Patient Agreement / Informed Consent for Female Patients (see http://www.soriatane.com/include/pi.pdf , pp. 23-26) Exclusion Criteria If the response to ANY item below is YES, then the patient should NOT receive acitretin. - Patient is pregnant, nursing, planning to become pregnant, or unreliable about using contraceptive methods - Patient has severe hepatic or renal impairment - Patient has chronic, hyperlipidemia uncontrolled by lipid-lowering agents - Concomitant use with methotrexate (risk of	

hepatitis), tetracyclines (risk of pseudotumor cerebri), or vitamin A and / or other systemic retinoids (risk of hypervitaminosis A)
- Hypersensitivity to acitretin, other product components, or other retinoids

Discontinuation Criteria

If the answer to ANY item below is YES, then acitretin should be discontinued and the patient referred for further evaluation.

- Lack of improvement in psoriasis symptoms after 3 months of acitretin therapy.
- Patient develops any of the following adverse effects:
Visual difficulties Papilledema, headache, nausea, vomiting, and visual disturbances (pseudotumor cerebri)

If the answer to the item below is YES, then acitretin should be discontinued and the patient counseled on potential risks of birth defects.

- Patient becomes pregnant, misses a period, stops using birth control, or has sexual intercourse without simultaneously using 2 effective contraceptive methods

Dispensing Limits

Max. 30 days' supply (to encourage compliance with counseling)

Monitoring

Check blood lipid concentrations before starting therapy and every 1 to 2 weeks for the first 4 to 8 weeks or until lipid response is established; monitor more frequently or for a longer period in patients at risk (e.g., those with diabetes mellitus, patient or family history of hyperlipidemia, obesity, increased alcohol use, or pancreatitis)
Check liver enzyme tests before starting therapy and every 1 to 2 weeks until stable, then as clinically

			indicated Perform periodic radiographic tests to evaluate patient for hyperostosis if acitretin is continued long-term or if patient develops symptoms consistent with hyperostosis Check blood glucose concentrations on a regular basis for possible development of diabetes mellitus Perform monthly pregnancy test Assess patient on a regular basis for potential depression and suicidality Counsel patient on a regular basis to reinforce avoidance of pregnancy Provide patient with a Medication Guide each time acitretin is dispensed, as required by law June 16th 2006 VISN 20 P&T Committee	
DE103	ACYCLOVIR 5% TOP OINT	ZOVIRAX	Restricted to Dermatology or local equivalent	FORMULARY
AM800	ACYCLOVIR NA INJ	ZOVIRAX	Restrictions per local facility	FORMULARY
AM800	ACYCLOVIR ORAL	ZOVIRAX	Open Formulary - no restrictions	FORMULARY
AM800	ADEFOVIR DIPIVOXIL ORAL	HEPSERA	Restricted to GI and ID Services or local facility equivalent.	FORMULARY
CV300	ADENOSINE INJ	ADENOCARD	Restricted to Cardiology Service or local equivalent	FORMULARY
XA603	ADHESIVE AEROSOL	N/A	Open Formulary - no restrictions	FORMULARY
XA603	ADHESIVE CEMENT	N/A	Open Formulary - no restrictions	FORMULARY
XA699	ADHESIVE REMOVER	N/A	Open Formulary - no restrictions	FORMULARY
XA900	ADHESIVE REMOVER PAD (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	ADHESIVE REMOVER SPRAY (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
AP200	ALBENDAZOLE ORAL	ALBENZA	Open Formulary - no restrictions	FORMULARY
BL500	ALBUMIN INJ 25% 50ML	ALBUMINAR	Restrictions per local facility	FORMULARY
RE102	ALBUTEROL INHALATION SOLUTION	PROVENTIL	Restricted to patients who have physical, visual, mental or cognitive impairments that prevent efficacious use of a metered dose inhaler (MDI) after adequate instruction, including the use of a spacer.	FORMULARY
RE109	ALBUTEROL 90MCG/IPRATROPIUM 18MCG 200DOSE ORAL INHL	COMBIVENT	Open Formulary - no restrictions	FORMULARY
RE102	ALBUTEROL CFC-F 90MCG 200DOSE ORAL INHALER	PROVENTIL	Open Formulary - no restrictions	FORMULARY

RE103	ALBUTEROL SULFATE 2MG, 4MG TAB	PROVENTIL	Open Formulary - no restrictions	FORMULARY
RE109	ALBUTEROL/IPRATROPIUM INHL, SOLN	N/A	Restricted to patients unable to utilize oral inhaler	FORMULARY
DE101	ALCOHOL ISOPROPYL 70% (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA105	ALCOHOL PREP PAD	N/A	Open Formulary - no restrictions	FORMULARY
TN900	ALCOHOL, ABSOLUTE INJ	N/A	Restrictions per local facility	FORMULARY
DE900	ALCOHOL, ISOPROPYL 70% 473ML	N/A	For use on wards.	FORMULARY
PH000	ALCOHOL,DENATURED 473ML	N/A	Open Formulary - no restrictions	FORMULARY
PH000	ALCOHOL,DENATURED 95% 5GAL.	N/A	Open Formulary - no restrictions	FORMULARY
TN101	ALCOHOL/DEXTROSE INJ	N/A	Open Formulary - no restrictions	FORMULARY
IM700	ALDESLEUKIN INJ	PROLEUKIN	Restrictions per local facility	FORMULARY
HS900	ALENDRONATE ORAL 10MG, 40MG, 70MG	FOSAMAX	Open Formulary - no restrictions	FORMULARY
CN101	ALFENTANIL INJ 0.5MG/ML 10ML	ALFENTA	Restrictions per local facility	FORMULARY
GA103	ALGINIC ACID/NA BICARB/CA STEARATE/MAG TRI CHEW ORAL	GAVISCON; = ALOH 80/MG TRISIL 20MG CHEW TAB	Open Formulary - no restrictions	FORMULARY
IM900	ALLERGENIC EXTRACT (VARIOUS)	N/A	Open Formulary - no restrictions	FORMULARY
MS400	ALLOPURINOL 100MG TAB	ZYLOPRIM	Open Formulary - no restrictions	FORMULARY
MS400	ALLOPURINOL 300MG TAB	ZYLOPRIM	Open Formulary - no restrictions	FORMULARY
GA199	ALOH/MGOH/SIMTH XTRA STRENGTH	MAALOX	Open Formulary - no restrictions	FORMULARY
CN302	ALPRAZOLAM ORAL	XANAX	Restricted to Psychiatry/Mental Health or local equivalent	FORMULARY
HS875	ALPROSTADIL URETHRAL SUPP (MUSE)	MUSE		FORMULARY
HS875	ALPROSTADIL INJ (CAVERJECT DRY POWDER VIALS)	CAVERJECT		FORMULARY
BL600	ALTEPLASE, RECOMBINANT INJ (TPA)	ACTIVASE	Restrictions per local facility	FORMULARY
DE450	ALUMINUM CHLORIDE HEXAHYDRATE	DRYSOL	Open Formulary - no restrictions	FORMULARY
GA101	ALUMINUM HYDROXIDE GEL 320MG/5ML	AMPHOGEL	Open Formulary - no restrictions	FORMULARY
DE900	ALUMINUM SULF/CALCIUM ACE POWDER PACKETS	DOMEBORO SOLUTION	Open Formulary - no restrictions	FORMULARY
AM800	AMANTADINE HCL 100MG CAP	SYMMETREL	Open Formulary - no restrictions	FORMULARY
AM800	AMANTADINE SYRUP 50MG/5ML 473M	SYMMETREL	Open Formulary - no restrictions	FORMULARY
AM300	AMIKACIN SULFATE INJ	AMIKIN	Restrictions per local facility	FORMULARY

TN501	AMINO ACID INJ 8.5% 500ML	AMINOSYN	Restrictions per local facility	FORMULARY
TN501	AMINO ACIDS/DEXTROSE INJ	N/A	Restrictions per local facility	FORMULARY
BL300	AMINOCAPROIC ACID 500MG TAB	AMICAR	Open Formulary - no restrictions	FORMULARY
BL300	AMINOCAPROIC ACID INJ 250MG/ML	AMICAR	Open Formulary - no restrictions	FORMULARY
RE104	AMINOPHYLLINE INJ 25MG/ML 10ML	TRUPHYLINE	Restrictions per local facility	FORMULARY
CV300	AMIODARONE INJ	CORDARONE	Restricted to Cardiology Service or local equivalent	FORMULARY
CV300	AMIODARONE ORAL TAB	CORDARONE	Restricted to Cardiology Service or local equivalent	FORMULARY
CN601	AMITRIPTYLINE HCL 10MG, 25MG, 50MG TAB	ELAVIL	Open Formulary - no restrictions	FORMULARY
CV200	AMLODIPINE ORAL TAB	NORVASC	Clinical Guidance for the Use of Formulary Long-Acting Dihydropyridine Calcium Channel Blockers VHA Pharmacy Benefits Management Strategic Healthcare Group and the Medical Advisory Panel The recommendations are based on current medical evidence and expert opinion from clinicians. The content of the document is dynamic and will be revised as new clinical data become available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. The clinician should utilize this guidance and interpret it in the clinical context of the individual patient. The following recommendations are provided for clinicians considering the use of a formulary long-acting dihydropyridine (LA DHP) calcium channel blocker (CCB) (e.g., amlodipine, felodipine, long-acting nifedipine) for the treatment of hypertension (HTN) and/or angina. Short-acting nifedipine should not be used for these conditions.	FORMULARY

Hypertension
(Amlodipine, Felodipine, or Long-Acting Nifedipine)

Thiazide-type diuretics are the preferred first line agents for patients with uncomplicated HTN. In addition, most patients will require more than one agent to control their blood pressure. Another class of medication [e.g., angiotensin-converting enzyme inhibitor (ACEI), long-acting CCB] may be considered in patients who have a contraindication to or are inadequately controlled on a thiazide-type diuretic OR in patients who have an indication for an agent in another antihypertensive class (e.g., beta-blocker in a patient with prior-myocardial infarction or symptomatic coronary ischemia; ACEI and beta-blocker in patients with systolic heart failure). For additional information, refer to www.oqp.med.va.gov for the VHA/DoD Clinical Practice Guideline for Management of Hypertension in Primary Care.

A formulary LA DHP may be considered in patients with HTN if they experience/have:
- Inadequate control on a thiazide-type diuretic
- Documented intolerance to a thiazide-type diuretic
- Contraindication to a thiazide-type diuretic
- Compelling indication for a LA DHP

Angina
(Amlodipine, Felodipine, or Long-Acting Nifedipine)

Patients with angina should be treated with a beta-adrenergic blocker. A CCB may be an option when a beta-adrenergic blocker alone or in combination with a long-acting nitrate is ineffective or contraindicated. Selection of a non DHP CCB (e.g.,

			diltiazem, verapamil) vs. a long-acting DHP in patients not on a beta-adrenergic blocker may depend on patient specific considerations. If a CCB is being considered in addition to therapy with a beta-adrenergic blocker, the long-acting DHP CCBs are preferred due to the potential for bradycardia or atrioventricular block with a non DHP CCB in combination with a beta-adrenergic blocker. A CCB may also be considered for additional blood pressure control and in patients with variant (Prinzmetal) angina. In addition, it is recommended that all patients with coronary artery disease who also have left ventricular systolic dysfunction and/or diabetes mellitus should be treated with an ACEI, unless contraindicated. For additional information, refer to www.oqp.med.va.gov for the VA/DoD Clinical Practice Guideline for Management of Ischemic Heart Disease. A formulary LA DHP may be considered in patients with angina if they experience/have: - Inadequate control on a beta-adrenergic blocker - Documented intolerance to a beta-adrenergic blocker - Contraindication to a beta-adrenergic blocker - Variant (Prinzmetal) angina and unable to tolerate or do not respond to diltiazem or verapamil Hypertension and/or Angina in Patient with Concomitant Heart Failure (Amlodipine or Felodipine) Patients with systolic HF and concomitant HTN should be maximized on therapy with agents such as diuretics, ACEIs, and beta-adrenergic blockers, and an angiotensin II receptor antagonist

			(ARB), hydralazine/nitrate, or aldosterone antagonist, as indicated; or beta-adrenergic blockers and long-acting nitrates in patients with concomitant angina, before adding other agents. In patients not adequately controlled on these agents, treatment with amlodipine or felodipine may be considered; these recommendations are based on data in patients with HF treated with amlodipine (patients enrolled in PRAISE on amlodipine included ~ 81% in NYHA class III HF, 19% in class IV, with a mean ejection fraction 21%), and in another trial of patients with HF treated with felodipine (patients evaluated in V-HeFT III on felodipine included ~ 79% patients in NYHA class II HF, 22% in class III, with a mean ejection fraction 29%). The CCBs diltiazem, nifedipine, and verapamil should be avoided in patients with systolic dysfunction. For additional information, refer to www.oqp.med.va.gov for the PBM-MAP Pharmacologic Management of Patients with Chronic Heart Failure. A formulary LA DHP may be considered in the following clinical situations: - For the treatment of HTN in patients with concomitant HF who are not adequately controlled on, or have documented intolerance or a contraindication to a diuretic, ACEI, beta-adrenergic blocker, and ARB, hydralazine, or aldosterone antagonist, as indicated - For the treatment of angina in patients with concomitant HF who are not adequately controlled on, or have documented intolerance or a contraindication to a beta-adrenergic blocker and long-acting nitrate

			VISN 20 P&T Committee, August 2007 Date Added: Date(s) Discussed: June 19, 1998 August 17, 2007	
RE900	AMMONIA AROMATIC INHALANT 0.33	N/A	Open Formulary - no restrictions	FORMULARY
MS300	AMMONIUM CHLORIDE INJ		Open Formulary - no restrictions	FORMULARY
DE350	AMMONIUM LACTATE 12% LOTION	LAC HYDRIN	Open Formulary - no restrictions	FORMULARY
TN499	AMMONIUM LACTATE CREAM	LAC HYDRIN	Open Formulary - no restrictions	FORMULARY
AM052	AMOXICILLIN 250MG CAP	AMOXIL	Open Formulary - no restrictions	FORMULARY
AM052	AMOXICILLIN ORAL SUSP 250MG/5ML	AMOXIL	Open Formulary - no restrictions	FORMULARY
AM052	AMOXICILLIN/CLAVULANATE K ORAL	AUGMENTIN	Restricted to ID Service or local equivalent	FORMULARY
AM700	AMPHOTERICIN B INJ 50MG/VIAL	FUNGIZONE	Open Formulary - no restrictions	FORMULARY

AM700	AMPHOTERICIN B LIPID COMPLEX INJ	ALBECET	Amphotericin B lipid complex (Abelcet®) is formulary, restricted to: Infectious Disease and Bone Marrow Transplant Services for patients who meet one of the following criteria: (a) patients with pre-existing renal insufficiency (e.g., serum creatinine >2mg/dl or measured creatinine clearance <25ml/min) not on dialysis; (b) patients who develop renal insufficiency (e.g., serum creatinine has doubled or is >2.5mg/dl) while receiving conventional amphotericin B; (c) patients on concomitant nephrotoxic agents (e.g., cyclosporine, tacrolimus); (d) patients on dialysis for acute reversible renal failure; or (e) bone marrow or solid organ transplant patients with baseline serum creatinine > 1.5mg/dl. Amphotericin B liposome (Ambisome®) is non-formulary, restricted to: Infectious Disease and Bone Marrow Transplant Services for patients who continue to have nephrotoxicity, severe infusion-related reactions (IRR) uncontrolled by premedications, or disseminated fungal infection to the brain while on amphotericin B lipid complex (Abelcet®). Date Added: Date(s) Discussed: June 15, 2001	FORMULARY
AM052	AMPICILLIN INJ 1GM/VIAL	OMNIPEN	Open Formulary - no restrictions	FORMULARY
AM052	AMPICILLIN INJ 2GM/VIAL	OMNIPEN	Open Formulary - no restrictions	FORMULARY
AM052	AMPICILLIN NA/SULBACTAM NA INJ	UNASYN	Restrictions per local facility	FORMULARY
CV250	AMYL NITRITE INHL	N/A	Open Formulary - no restrictions	FORMULARY
BL400	ANAGRELIDE HCL ORAL CAPSULE	AGRYLIN	Anagrelide is restricted as second-line to patients who have intolerance and/or ineffectiveness to hydroxyurea. August 2007 VISN 20 P&T Committee	FORMULARY
AN900	ANASTRAZOLE ORAL TAB	ARIMIDEX	Anastrozole is formulary, restricted to Hematology/Oncology Service or local facility equivalent for use in postmenopausal women with estrogen hormone-receptor positive breast cancer. 11/18/2005 VISN 20 P&T	FORMULARY

DE802	ANTHRALIN 0.1% TOP CREAM	ANTHRADERM	Open Formulary - no restrictions	FORMULARY
DE802	ANTHRALIN 0.5% TOP CREAM	ANTHRADERM	Open Formulary - no restrictions	FORMULARY
DE802	ANTHRALIN 1% TOP CREAM	ANTHRADERM	Open Formulary - no restrictions	FORMULARY
BL500	ANTIHEMOPHILIC FACTOR,HUMAN INJ	HEMOFIL	Restrictions per local facility	FORMULARY
OT400	ANTIPYRINE/BENZOCAINE/GLYCERIN OTIC SOLN	AURALGAN	Open Formulary - no restrictions	FORMULARY
IM900	ANTI-THYMOCYTE GLOBULIN INJ	ATGAM	Restrictions per local facility	FORMULARY
IM300	ANTIVENIN,CROTALIDAE POLYVALENT INJ	CROFAB	Open Formulary - no restrictions	FORMULARY
CN500	APOMORPHINE ORAL	N/A	Restricted to Neurology Service or local equivalent.	FORMULARY
XA900	APPLIANCE CLEANSING SUPPLIES	N/A	Open Formulary - no restrictions	FORMULARY
OP900	APRACLONIDINE HCL OPH SOLN	IODIPINE	Restricted to Ophthalmology or eye clinic	FORMULARY
GA605	APREPITANT CAP,ORAL	EMEND	Aprepitant oral capsule is restricted to use by Oncology for the prevention of chemotherapy-induced nausea and vomiting (CINV) with highly-emetogenic or moderately-emetogenic chemotherapy regimens in combination with other anti-emetics. Aprepitant (Emend) VA National Criteria for Use: Prevention of chemotherapy-induced nausea and vomiting May 2009 VHA Pharmacy Benefits Management Services and Medical Advisory Panel EXCLUSION CRITERIA (if ONE is checked, patient is not eligible) Hypersensitivity to aprepitant Patients on concurrent pimozide or cisapride (aprepitant is a weak-moderate dose dependent inhibitor of CYP3A4) Chemotherapy regimens with minimal, low, or moderate potential for incidence of emetogenicity (except the combination of cyclophosphamide plus an anthracycline for breast cancer as noted below)	FORMULARY

INCLUSION CRITERIA**
Highly emetogenic chemotherapy* (includes multiple moderately
emetogenic drugs) in combination with a 5HT3 antagonist and dexamethasone
Moderately emetogenic chemotherapy* regimens (consisting of
cyclophosphamide plus an anthracycline for breast cancer) in combination
with a 5 HT3 antagonist and dexamethasone
Patients who fail standard antiemetic therapy with a 5HT3
antagonist plus dexamethasone for moderately emetogenic regimens

DOSING RECOMMENDATIONS

Highly Emetogenic Chemotherapy

Drug	Day 1	prior to Day 2	Day 3	Day 4
chemotherapy				
Aprepitant	125 mg orally	80 mg orally	80 mg orally	None
Dexamethasone+	12 mg orally	8 mg orally	8 mg orally	8 mg orally
	Once daily	Once daily	Once daily	Once daily
Ondansetron	8 mg IV (or 0.15mg/kg) or 24mg orally	None	None	None

Moderately Emetogenic Chemotherapy (cyclophosphamide plus an anthracycline)

Drug	Day 1	prior to Day 2	Day 3
chemotherapy			
Aprepitant	125 mg orally	80 mg orally	80 mg orally
Dexamethasone+	12 mg orally	8 mg orally	8 mg orally
	Once daily	None	None
Ondansetron	8 mg orally	None	None
	Once daily		

MONITORING
Aprepitant is a substrate for and inhibitor of CYP3A4. Drug
interactions with chemotherapy drugs have not been investigated even
though several are metabolized by CYP3A4. In clinical

			trials, there was an increased incidence of infections, neutropenia, and pulmonary toxicity that may be the result of a drug interaction. Monitor all patients for adverse events when adding aprepitant, especially in patients receiving chemotherapy drugs metabolized by CYP3A4. For patients on chronic warfarin therapy, closely monitor the INR in the 2 weeks following the initiation of the 3 day aprepitant regimen (especially days 7-10) due to the potential for a significant decrease in the INR. *See Appendix ** Patients at high risk for chemotherapy-induced nausea and vomiting include: patients with poor emesis control on previous chemotherapy, females, age under 50, history of motion sickness, history of hyperemesis gravidarum, history of postoperative nausea and vomiting + If steroids are part of the chemotherapy regimen, for example in lymphoma and multiple myeloma, dexamethasone is not required as part of the antiemetic regimen. The chemotherapy regimen steroid dose should not be reduced when aprepitant is used. VISN 20 P&T Committee, June 2009 , Date Added: October 17, 2008 Date(s) Discussed:	
XA204	AQUACEL RIBBON	AQUACEL	Open Formulary - no restrictions	FORMULARY

CN709	ARIPIPRAZOLE INJ	ABILIFY	Injectable aripiprazole and olanzapine are restricted to Mental Health/Psychiatry Service or local facility equivalent for use in patients receiving care in an emergency room or on an inpatient floor as monotherapy for the treatment of acute agitation associated with schizophrenia or bipolar I mania when the use of an oral antipsychotic is not feasible. November 2004, February 2008 VISN 20 P&T Committee	FORMULARY
CN709	ARIPIPRAZOLE ORAL TAB	ABILIFY	VISN 20 Guidelines for Atypical Antipsychotics Atypical antipsychotics are restricted to the treatment of first episode psychosis or chronic psychosis in relapse. (national guidelines) First (and 2nd) line atypical antipsychotics: (alphabetical, no prescribed hierarchy) Aripiprazole Quetiapine Risperidone Ziprasidone 3rd line Olanzapine Clozapine (if poor response to AT LEAST 2 other atypical antipchotics) April 2007 VISN 20 P&T Committee VISN 20 Guidelines for Screening and Monitoring Patients Prescribed Atypical Antipsychotics Baseline Screening Guidelines Prior to initiating a new atypical antipsychotic, it is recommended that clinicians: 1. Obtain/review the patient's personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease. 2. Provide basic education about signs and	FORMULARY

			symptoms of Hyperglycemia Diabetic ketoacidosis 3. Obtain or document in CPRS baseline measures for Fasting lipid panel and fasting blood sugar (or an HgA1C if it is difficult to get the patient's cooperation for a fasting blood sugar) Weight (entered into CPRS Cover Sheet) Height (entered into CPRS Cover Sheet) Blood pressure (entered into CPRS Cover Sheet) Subsequent Monitoring Guidelines During the first 4 months of treatment, it is recommended that clinicians: 1. Obtain a fasting blood sugar and lipid panel at least once. 2. Record weight at each visit; note any increases. 3. Record blood pressure at least once. At one year of treatment, it is recommended that clinicians: 1. Make sure that a recent weight and blood pressure are recorded in the chart. 2. Repeat fasting glucose. 3. Order a lipid panel if there are concerns about significant weight gain, personal or family risk factors for cardiovascular disease, or past abnormal laboratory results. After one year, monitoring is at the clinician's discretion. Considerations that would warrant further annual or more frequent screening include: 1. Significant amount of weight gain or pre-existing obesity 2. Family or personal history of other significant risk factors for cardiovascular disease or diabetes	

			3. Past abnormal laboratory screening results Summary of VISN 20 Screening and Monitoring Recommendations Measure Baseline First 4 Months One Year Personal/Family History Yes Review any changes Patient/Family Education Yes Height Yes Weight (BMI) Yes Each visit Yes Fasting glucose/ Hgb A1c Yes At least once Yes Fasting lipid profile Yes At least once If clinically indicated Blood pressure Yes At least once Yes June 2005 VISN 20 P&T	
OR500	ARTIFICIAL SALIVA (OTC)	SALIVA SUBSTITUTE	Open Formulary - no restrictions	FORMULARY
OP500	ARTIFICIAL TEARS - METHYLCELLULOSE/DEXTRAN-70	BION TEARS, AKWA TEARS, ISOPTO TEARS	Open Formulary - no restrictions	FORMULARY
OP500	ARTIFICIAL TEARS - POLYVINYL ALCOHOL (PF) (OTC)	TERGEN, REFRESH	Open Formulary - no restrictions	FORMULARY
CN103	ASA/BUTALBITAL/CAFN ORAL	FIORINAL	Open Formulary - no restrictions	FORMULARY
VT400	ASCORBIC ACID 500MG TAB	VITAMIN C	Open Formulary - no restrictions	FORMULARY
VT400	ASCORBIC ACID INJ 500MG/2ML	VITAMIN C	Open Formulary - no restrictions	FORMULARY
AN900	ASPARAGINASE INJ	ELSPAR	Restrictions per local facility	FORMULARY
BL700	ASPIRIN + DIPYRIDAMOLE SA ORAL	AGGRENOX	The combination of aspirin and sustained-release dipyridamole (Aggrenox) is restricted to use or approval by Neurology or local facility equivalent for patients who have failed aspirin therapy.	FORMULARY
CN103	ASPIRIN 325MG EC TAB	ECOTRIN	Open Formulary - no restrictions	FORMULARY
CN103	ASPIRIN 325MG TAB	APSIRIN	Open Formulary - no restrictions	FORMULARY
CN103	ASPIRIN 81MG CHEW TAB	BABY ASPIRIN	Open Formulary - no restrictions	FORMULARY
CN103	ASPIRIN 81MG EC TAB	N/A	Open Formulary - no restrictions	FORMULARY
CN103	ASPIRIN BUFFERED ORAL (OTC)	BUFFERIN	Open Formulary - no restrictions	FORMULARY
CN103	ASPIRIN SUPPOSITORY	N/A	Open Formulary - no restrictions	FORMULARY

AM800	ATAZANAVIR SO4 ORAL	REYATAZ	Formulary, restricted to the VA national criteria for use: Use of atazanavir should be limited to treatment naïve and treatment experienced HIV-infected patients who meet one of the following criteria: (1) For treatment naïve patients with a history of cardiovascular disease or multiple risk factor for cardiovascular disease OR (2) treatment naïve patients who would be likely to fail any regimen of HAART that requires more than once daily treatment and who are not candidates for therapy with other DHHS-recommended once daily regimens. (3) For treatment experienced patients with a documented intolerance to the current preferred protease inhibitors OR (4) treatment experienced patients clinically and/or virologically stable on an anti-retroviral regimen who are experiencing uncontrollable LDL cholesterol and/or triglyceride levels. Patients with uncontrolled dyslipidemia includes patients who do not reach VHA recommended target goals with lifestyle changes and/or pharmacologic intervention. OR (5) Patients with documented resistance to other protease inhibitors where ritonavir-boosted atazanavir would be expected to have activity. Date Added: November 21, 2003 Date(s) Discussed:	FORMULARY
CV100	ATENOLOL 50MG, 100MG TAB	TENORMIN	Open Formulary - no restrictions	FORMULARY
CV100	ATENOLOL INJ	TENORMIN	Restrictions per local facility	FORMULARY
CV400	ATENOLOL/CHLORTHALIDONE ORAL TAB	TENORETIC	Open Formulary - no restrictions	FORMULARY
AP109	ATOVAQUONE ORAL	MEPRON	Restricted to ID Service or local equivalent	FORMULARY
MS300	ATRACURIUM INJ	N/A	Restrictions per local facility	FORMULARY
AU350	ATROPINE INJ 0.1MG/ML 10ML SYR	N/A	Open Formulary - no restrictions	FORMULARY
AU350	ATROPINE INJ 0.4MG/ML 1ML INJ, 20ML MDV	N/A	Open Formulary - no restrictions	FORMULARY
OP600	ATROPINE OPHTH 1% SOLN 15ML	ISOPTO ATROPINE	Open Formulary - no restrictions	FORMULARY
OP600	ATROPINE SULFATE OPH OINT	OCU-TROPINE	Open Formulary - no restrictions	FORMULARY

XA305	ATTENDS BRIEFS, LARGE 96/CASE	ATTENDS	Open Formulary - no restrictions	FORMULARY
XA305	ATTENDS BRIEFS, MEDIUM 96/CASE	ATTENDS	Open Formulary - no restrictions	FORMULARY
MS106	AURANOFIN ORAL	RIDAURA	Open Formulary - no restrictions	FORMULARY
MS106	AUROTHIOGLUCOSE SUSP INJ	SOLGANOL	Restrictions per local facility	FORMULARY
AN300	AZACITIDINE INJ	VIDAZA	VISN 20 Criteria for Azacitidine Restricted to use by Hematologists and Oncologists #1 - Diagnosis Initial therapy in the patients with the following myelodysplastic subtypes: Refractory anemia (RA) or refractory anemia with ringed sideroblasts (RARS) (If accompanied by neutropenia OR thrombocytopenia OR clinical hemorrhage requiring platelet transfusions OR anemia requiring red blood cell transfusions) Refractory anemia with excess blasts (RAEB) Refractory anemia with excess blasts in transformation (RAEB-T) Chronic myelomonocytic leukemia (CMMoL) If Yes to any subtype, go to #2. If No, patient is ineligible for azacitidine #2 Exclusion Criteria Patient with any of the following conditions: ECOG Performance Status >2 http://www.ecog.org/general/perf_stat.html Serum Creatinine > 1.5 X ULN Diagnosis of metabolic acidosis Total bilirubin > 1.5 X ULN AST/ALT > 2 X ULN Patients with extensive hepatic tumor burden due to metastatic disease Uncontrolled congestive heart failure	FORMULARY

Hypersensitivity to mannitol
Life expectancy < 4 months
Pregnancy
Women actively breastfeeding

If Yes to any condition in #2, patient is ineligible for azacitidine.

#3 Discontinuation

Progression of disease during initial 4 months of treatment (see Relapse criteria)

Stable disease after initial 4 months of treatment

Unacceptable toxicity

Relapse after initial response. Relapse criteria defined below:
Relapse from CR- >5% myeloblasts in bone marrow
Relapse from PR - > 30% bone marrow blasts (in patients with RA or RARS, return to pretreatment peripheral blood values or decrease in RBC transfusions by more than 50% in patients receiving transfusions of greater than 1unit/month alone or in conjunction with bone marrow results)
Relapse from Improvement - Return of peripheral blood counts to pretreatment values or decrease in RBC transfusions by more than 50% in patients receiving transfusions of greater than 1unit/month

Transformation to Acute Myelogenous Leukemia

If Yes to any, discontinue azacitidine therapy

Monitoring

Complete blood counts and assessment of renal function prior to each cycle and as needed (See Azacitidine drug monograph for dose reductions based on WBC and platelet counts)

			Premedicate with oral prochlorperazine or oral ondansetron If no beneficial bone marrow effect from initial dose by day 57 without significant toxicity, increase dose to 100mg/m2/day for 7 days (optional) Assess effect on bone marrow after fourth cycle (day 113) (optional) (see Discontinuation above) Reduce dose by 50% on next course for unexplained reductions in serum bicarbonate to < 20 mEq/L; assess for renal tubular acidosis (alkaline urine, hypokalemia to <3 mEq/L along with drop in serum bicarbonate) If unexplained increase in BUN or serum creatinine, delay dose until values return to normal or baseline, then resume at 50% dose reduction on next course October 21, 2005 Date Added: August 19, 2005 Date(s) Discussed: October 21, 2005	
IM600	AZATHIOPRINE INJ	IMURAN	Open Formulary - no restrictions	FORMULARY
IM600	AZATHIOPRINE 50MG TAB	IMURAN	Open Formulary - no restrictions	FORMULARY
AM200	AZITHROMYCIN INJ	ZITHROMAX	Restrictions per local facility	FORMULARY
AM200	AZITHROMYCIN ORAL	ZITHROMAX	Restrictions per local facility	FORMULARY
AM130	AZTREONAM INJ	AZACTAM	Restrictions per local facility	FORMULARY
DE109	BACITRACIN 500/POLYMYXIN 10000U/GM OINT (OTC)	POLYSPORIN	Open Formulary - no restrictions	FORMULARY
DE109	BACITRACIN 500/POLYMYXIN 10000U/GM PWD (OTC)	POLYSPORIN	Open Formulary - no restrictions	FORMULARY
AM900	BACITRACIN INJ 50,000 UNITS	AK-TRACIN	Restrictions per local facility	FORMULARY
DE101	BACITRACIN TOP OINT 30GM	AK-TRACIN	Open Formulary - no restrictions	FORMULARY
OP350	BACITRACIN/HC /NEO/POLYMYX OPH OINT	CORTISPORIN	Open Formulary - no restrictions	FORMULARY
OP209	BACITRACIN/NEOMYCIN/POLYMYXIN OPH OINT	NEOSPORIN	Open Formulary - no restrictions	FORMULARY

OP209	BACITRACIN/POLYMYXIN OPH OINT	POLYSPORIN	Open Formulary - no restrictions	FORMULARY
MS200	BACLOFEN 10MG TAB	LIORESAL	Open Formulary - no restrictions	FORMULARY
MS200	BACLOFEN INJ	LIORESAL	Baclofen for intrathecal injection (preservative-free) is restricted to VA Anesthesiology and VA Pain Service. Feb 2007 VISN 20 P&T	FORMULARY
XA501	BAG BEDSIDE URINARYBAG	N/A	Open Formulary - no restrictions	FORMULARY
XA799	BAG FEEDING W/TUBE	N/A	Open Formulary - no restrictions	FORMULARY
XA607	BAG IRRIGATOR W/CONE	N/A	Open Formulary - no restrictions	FORMULARY
XA508	BAG LEG DISPOSABLE	N/A	Open Formulary - no restrictions	FORMULARY
XA508	BAG LEG DISPOSABLE, FLIP-FLOW	N/A	Open Formulary - no restrictions	FORMULARY
XA508	BAG LEG REUSABLE	N/A	Open Formulary - no restrictions	FORMULARY
XA508	BAG LEG REUSABLE W/ VALVE	N/A	Open Formulary - no restrictions	FORMULARY
XA508	BAG,LEG (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA701	BAG,TUBE FEEDING (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA701	BAG,TUBE FEEDING GRAVITY (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
OP500	BALANCED SALT SOLUTION 18ML	IRRIGATING EYE SOLN, OPH	Open Formulary - no restrictions	FORMULARY
OP500	BALANCED SALT SOLUTION/GLUTATHIONE 500ML	IRRIGATING EYE SOLN, OPH	Open Formulary - no restrictions	FORMULARY
GA900	BALSALAZIDE ORAL CAPSULE	COLAZA	Balsalazide is formulary, restricted as second-line agent to sulfasalazine for patients WITH ulcerative colitis, with or without Crohn's disease. [Mesalamine is formulary, restricted as second-line agent to sulfasalazine for patients with Crohn's disease WITHOUT ulcerative colitis.] February 2008	FORMULARY
DE900	BALSAM PERU/CASTOR OIL/TRYPSIN AEROSOL	GRANULEX	Open Formulary - no restrictions	FORMULARY
XA108	BANDAGE ELASTIC ADHESIVE	N/A	Open Formulary - no restrictions	FORMULARY
XA109	BANDAGE TUBULAR ELASTIC (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA108	BANDAGE,ACE 3 INCH	ACE	Open Formulary - no restrictions	FORMULARY
XA104	BANDAGE,ADHESIVE (1IN X 3IN) (PLASTIC, FABRIC)	N/A	Open Formulary - no restrictions	FORMULARY
XA102	BANDAGE,ADHESIVE FLEXIBLE FABRIC 2IN X 3-1/2IN	BAND-AID 2IN	Open Formulary - no restrictions	FORMULARY
XA104	BAND-AID (OTC)	BAND-AID	Open Formulary - no restrictions	FORMULARY

DX101	BARIUM 0.1% W/V, 0.1% W/W RADIO CONTRAST AGENT	VOLUMEN	Open Formulary - no restrictions	FORMULARY
DX101	BARIUM 2% W/V RADIO CONTRAST AGENT	READI-CAT	Open Formulary - no restrictions	FORMULARY
XA604	BARRIER OSTOMY TWO-PIECE FLANGE SIZE 1 1/2 - 4	N/A	Open Formulary - no restrictions	FORMULARY
XA604	BARRIER,HOLLIHESIVE H#7701 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	BARRIER,OSTOMY H#3702 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	BARRIER,OSTOMY H#3703 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	BARRIER,OSTOMY H#3704 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	BARRIER,OSTOMY H#3706 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	BARRIER,OSTOMY H#3707 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
IM600	BASILIXIMAB INJ	SIMULECT	Restricted to transplant services or local equivalent.	FORMULARY
DE350	BATH OIL (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
IM100	BCG VACCINE INJ 50MG/ML 2ML	THERACYS	Open Formulary - no restrictions	FORMULARY
AN900	BCG,TICE VACCINE	TICE	Restrictions per local facility	FORMULARY
XA900	BEDPAN,DISPOSABLE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CN101	BELLADONNA/OPIUM 60MG SUPP	B&O	Open Formulary - no restrictions	FORMULARY
XA605	BELT,OSTOMY (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CV702	BENAZEPRIL ORAL	LOTENSIN	Open Formulary - no restrictions	FORMULARY
OP900	BENOXINATE HCL/FLUORESCEIN NA OPH SOLN	FLURESS	Restricted to Ophthalmology or eye clinic	FORMULARY
OP900	BENZALKONIUM CHLORIDE/TYLOXAPOL OPH SOLN (OTC)	ENUCLENE	Open Formulary - no restrictions	FORMULARY
NT300	BENZOCAINE DENTAL GEL (OTC)	ANBESOL	Open Formulary - no restrictions	FORMULARY
DE900	BENZOIN COMPOUND 30%/ISOPROPYL ALCOHOL 44.8% SPRAY	N/A	Open Formulary - no restrictions	FORMULARY
XA604	BENZOIN TINCTURE TOPICAL	N/A	Open Formulary - no restrictions	FORMULARY
RE302	BENZONATATE 100MG CAP	TESSALON	Second line agent for cough suppression	FORMULARY
DE752	BENZOYL PEROXIDE 10% LOTION (OTC)	BENZAC	Open Formulary - no restrictions	FORMULARY
DE752	BENZOYL PEROXIDE 10% TOP GEL	BENZAC	Open Formulary - no restrictions	FORMULARY
DE752	BENZOYL PEROXIDE 5% LOTION (OTC)	BENZAC	Open Formulary - no restrictions	FORMULARY
DE752	BENZOYL PEROXIDE 5% TOP GEL	BENZAC	Open Formulary - no restrictions	FORMULARY

DE752	BENZOYL PEROXIDE 5%/ERYTHROMYCIN 3% TOP GEL	BENZAMYCIN	Open Formulary - no restrictions	FORMULARY
AU350	BENZTROPINE INJ 1MG/ML 2ML	COGENTIN	Open Formulary - no restrictions	FORMULARY
AU350	BENZTROPINE MESYLATE 0.5MG, 1MG, 2MG TAB	COGENTIN	Open Formulary - no restrictions	FORMULARY
AN900	BETAMETHASONE DIPROPIONATE TOPICAL CREAM	DIPROSONE	Open Formulary - no restrictions	FORMULARY
CV800	BETAMETHASONE DIPROPIONATE TOPICAL OINTMENT	DIPROSONE	Open Formulary - no restrictions	FORMULARY
DE200	BETAMETHASONE VALERATE 0.1% OINTMENT	VALISONE	Open Formulary - no restrictions	FORMULARY
DE400	BETAMETHASONE VALERATE TOPICAL CREAM	VALISONE	Open Formulary - no restrictions	FORMULARY
TN499	BETAMETHASONE VALERATE TOPICAL LOTION	VALISONE	Open Formulary - no restrictions	FORMULARY
OP101	BETAXOLOL HCL 0.25% OPH SUSP	BETOPTIC	Betaxolol ophthalmic solution is third line ophthalmic beta blocker after timolol and levobunolol. Betaxolol ophthalmic suspension is fourth line ophthalmic beta blocker, reserved for patients intolerant to betaxolol ophthalmic solution. January 2010 VISN 20 P&T Committee	FORMULARY
OP101	BETAXOLOL HCL 0.5% OPH SOLN	BETOPTIC	Betaxolol ophthalmic solution is third line ophthalmic beta blocker after timolol and levobunolol. Betaxolol ophthalmic suspension is fourth line ophthalmic beta blocker, reserved for patients intolerant to betaxolol ophthalmic solution. January 2010 VISN 20 P&T Committee	FORMULARY
AU300	BETHANECHOL CHLORIDE 5MG, 10MG, 20MG TAB	URECHOLINE	Open Formulary - no restrictions	FORMULARY
AU300	BETHANECHOL INJ 5MG/ML 1ML	URECHOLINE	Open Formulary - no restrictions	FORMULARY
AN900	BEVACIZUMAB	AVASTIN	FORMULARY, CFU	FORMULARY
AN900	BEVACIZUMAB INJ	AVASTIN	VA National Criteria For Use: Intravenous Bevacizumab (Avastin) November 2009 VHA Pharmacy Benefits Management Services and the Medical Advisory Panel EXCLUSION CRITERIA (If one is selected, patient is not eligible for bevacizumab)	FORMULARY

			o Recent hemoptysis (defined as > ½ teaspoonful of blood) o Unstable cardiac condition, which may/may not include the following: 0 Major cardiovascular event within previous 12 months (examples: uncontrolled HTN, MI, unstable angina, serious cardiac arrhythmia requiring medication, peripheral and arterial ischemic events) 0 Uncontrolled NYHA grade II or greater CHF if patient has a history of prior anthracycline exposure or prior radiotherapy to the chest wall o Pre-existing proteinuria (> 500mg urine protein/24 hrs) o Major surgery within prior 28 days o Non-healing wound or fracture o Pregnancy or lactation o NSCLC with predominant squamous cell histology o Untreated CNS metastases o Therapeutic anticoagulation, unless on stabilized outpatient doses (see Issues for Consideration) o Chronic anti-platelet therapy, NSAIDs (including aspirin > 325mg/day); these drugs can affect platelet function and put patient at increased risk of bleeding, especially if concomitant marrow-suppressive chemotherapy causes thrombocytopenia; some may also cause GI irritation leading to ulcers/inflammation and potentially increase risk of GI perforation, particularly in colorectal cancer patients o ECOG performance status > 2 (see Issues for Consideration) o Hypersensitivity to bevacizumab o Pre-existing bleeding diathesis or coagulopathy INCLUSION CRITERIA (Check indication AND must meet all criteria listed below) o Metastatic Colorectal Cancer (MCC), in combination with a	

			fluoropyrimidine-based chemotherapy regimen as first-line therapy OR o Metastatic Colorectal Cancer (MCC), in combination with a fluoropyrimidine-based chemotherapy regimen as second-line therapy, if bevacizumab was NOT used in the first-line setting OR o Non-Small Cell Lung Cancer (NSCLC), in combination with a two-drug chemotherapy regimen containing a platinum-based drug for stage IIIB or IV without prior therapy for advanced disease AND o Age > 18 years o No prior bevacizumab given intravenously o ECOG Performance Status 0, 1 or 2 o Life expectancy > 3 months o Adequate hematologic function (WBC, Hgb, Platelets all WNL) o Adequate renal and hepatic function (See Issues for Consideration) NOTE o Data are awaited regarding whether bevacizumab provides clinical benefit and/or survival benefit in progressive glioblastoma, in the first-line treatment of metastatic breast cancer or in first-line treatment of metastatic renal cell carcinoma. Until that time, the decision to use bevacizumab in select patients with refractory glioblastoma, metastatic breast cancer or metastatic renal cell carcinoma can be decided on a case-by-case basis. DOSAGE AND ADMINISTRATION o Metastatic colorectal cancer, with fluoropyrimidine-containing regimens 0 Bevacizumab 5 mg/kg or 10 mg/kg IV every 14 days	

			with 5-FU-based regimens 0 Bevacizumab 7.5 mg/kg IV every 21 days with capecitabine-containing regimens o Non-Small Cell Lung Cancer, with a two-drug, platinum-based chemotherapy regimen 0 Bevacizumab 15mg/kg IV every 21 days RECOMMENDED MONITORING o Blood pressure should be monitored prior to each treatment, especially among those with age > 65 years. Those who develop hypertension or worsening of existing HTN may require more frequent monitoring. Antihypertensives may be needed. Bevacizumab should be discontinued in patients with hypertensive crises. o Check urinalysis or urine dipstick for protein at least on a monthly basis. Patients with 2+ or greater urine dipstick should be further assessed via 24-hour urine collection. If urine protein > 2 g/24 hrs, interrupt therapy until proteinuria < 2 g/24 hrs. Bevacizumab should be discontinued in patients with grades 3 / 4 proteinuria (defined as 4+ protein or nephrotic syndrome). o Monitor for bleeding. Bevacizumab should be discontinued in patients with grades 3 / 4 bleeding (defined as requiring transfusion and/or other interventional procedure for hemostasis and catastrophic bleeding). o Monitor for venous and/or arterial thromboembolic events (refer to Issues for Consideration) o Monitor CBC, differential at baseline and prior to each cycle.	

			ISSUES FOR CONSIDERATION o Should a Venous Thromboembolic Event (VTE) occur, bevacizumab should be held for a minimum of two (2) weeks until anticoagulation can be stabilized. Bevacizumab may be resumed after that time. o Should an Arterial Thromboembolic Event (ATE) occur, bevacizumab should be held for at least 6 months; patient should be stable and asymptomatic before considering resumption of bevacizumab.. Aspirin < 325 mg/day may be considered in those at high risk for development of ATE (ie. Age > 65 years). o Clinical trials have primarily included patients with ECOG performance status 0-1. ECOG performance status 2 is defined as being ambulatory and capable of all self care, but unable to carry out any work activities; patients are up and about more than 50% of waking hours. The decision to use bevacizumab in those with ECOG PS 2 should be made on a case-by-case basis with close monitoring. o Bevacizumab should not be started within 4 weeks after a major surgical procedure. If treatment is needed sooner, chemotherapy can be given within the 4-week time frame with bevacizumab given later. If already receiving bevacizumab, but require an elective major surgical procedure, hold bevacizumab for 6-8 weeks prior to procedure. o Bevacizumab has not been studied in populations with renal and/or hepatic insufficiency. Based on the pharmacokinetics of bevacizumab, issues with drug metabolism or elimination would not be expected. Despite this, the decision to use bevacizumab in populations with renal and/or hepatic insufficiency	

should be
made on a case-by-case basis with close monitoring.

RENEWAL CRITERIA

o Tumor response should be assessed every 3 cycles (every 6 weeks
for MCC; every 9 weeks for NSCLC)
o Toxicity should be assessed prior to each cycle

November 2009 VISN 20 P&T Committee

Patient Selection for off label use of intravitreal bevacizumab in the treatment of AMD

o Use of intravitreal bevacizumab is restricted to retinal specialists or those who are trained in intravitreal injections and AMD diagnosis.
o Patients have failed to show benefit or stabilization after therapy with an FDA approved agent for treatment of AMD (i.e., pegaptanib, ranibizumab or verteporfin/PDT)
o Patients with active periocular or ocular infections, a history of gastrointestinal perforation, wound healing complications, arterial thromboembolic events, uncontrolled hypertension and recent history of myocardial infarction (< 1 year) should not receive bevacizumab

Documentation in the medical record should include but not be limited to:

o Discussion of the off label status of bevacizumab and the risks of therapy
o Patient understanding of the risks and benefits of bevacizumab therapy as documented with an informed consent
o Actual dosage used, the lot number of the vial, date and time of administration and any unusual reactions
o Planned course of therapy and follow up timeline

Procurement of intravitreal bevacizumab

o The currently available product is a single entry, intravenous solution

			o Compounding pharmacies prepare and ship bevacizumab for intravitreal use o Any compounding of bevacizumab must follow USP 797 and meet sterility and stability standards set by USP o A draft compounding policy with instructions follows: Preparation: 1. It is recommended that all manipulations be performed using proper aseptic technique under a laminar flow hood (IS0 Class 5) in compliance with USP Chapter 797. 2. The pharmacist punctures the vial of bevacizumab with a device called a Mini-Spike 3. Dispensing Pin with Security Clips (B-Braun, catalog # DP-1000SC). The use of this (or similar) device is recommended because bevacizumab is available in a ???Single-Use??? vial so puncturing of the vial multiple times is not recommended. Please note that this device contains a bacterial retentive air-venting filter, but does not actually filter the drug itself. Filtering the drug is not advised since bevacizumab, a protein, may stick to the filter. 4. The pharmacist then draws up 0.12 ml of bevacizumab into multiple 1ml polypropylene tuberculin syringes (Becton Dickinson & Co, Franklin, NJ 07417). A sterile cap is placed on each syringe. The syringes are then labeled, placed in light-resistant brown bags to protect from light, and stored in a refrigerator at 2-8??C until used for injection. 5. Approximately 25 syringes can be drawn up from a 4 ml vial of bevacizumab. The drug is available as a solution and is not diluted, reconstituted or altered in any way. Discard any unused portion. a. A 14-day Beyond-Use Date (BUD) is assigned to each syringe based on USP Chapter <797> for a low-risk, refrigerated preparation. If the Beyond-Use Dating of the low-risk level compound does not exceed this published dating in USP Chapter <797>, sterility testing is not required except for high-risk level batches of more than 25 units. If the BUD exceeds the published	

			USP Chapter <797> recommendations, then sterility testing is required. Although stability information of the drug in syringes is not currently available, a 14-day theoretically predicted beyond-use date appears to be extremely conservative since the drug is stable in its original glass vial for 18 months. b. Prior to injection, a sterile standard 30-gauge needle (5/8 inch) is placed on the syringe, and the plunger is advanced to 0.05ml (50??l) so that all the dead space contains drug. January 2010 VISN 20 P&T Date Added: Date(s) Discussed: January 21, 2005 January 15, 2010	
AN200	BICALUTAMIDE 50MG TAB	CASODEX	Open Formulary - no restrictions	FORMULARY
RS300	BISACODYL 10MG ENEMA	DULCOLAX	Open Formulary - no restrictions	FORMULARY
RS300	BISACODYL 10MG RTL SUPP (OTC)	DULCOLAX	Open Formulary - no restrictions	FORMULARY
GA204	BISACODYL 5MG EC TAB	DULCOLAX	Open Formulary - no restrictions	FORMULARY
GA400	BISMUTH SUBSALICYLATE ORAL	PEPTO-BISMOL	Open Formulary - no restrictions	FORMULARY
CV100	BISOPROLOL ORAL TAB	N/A	Extended-release metoprolol (Toprol XL) and bisoprolol are formulary, restricted to patients with Chronic Heart Failure.	FORMULARY
BL110	BIVALIRUDIN INJ	ANGIOMAX	Restrictions per local facility	FORMULARY
AN200	BLEOMYCIN SO4 INJ	BLENOXANE	Restrictions per local facility	FORMULARY

DX900	BLOOD GLUCOSE MONITORING DEVICES AND STRIPS	N/A	Patients with stable glycemic control are limited to the following quantities of glucose test strips: patients using insulin may receive up to 300 strips per 90 days; patients using any oral agent may receive up to 50 strips per 90 days; and patients using diet or lifestyle changes may receive up to 50 strips per year. Limitations for patients without stable glycemic control will be determined by each local facility. VISN P&T Committee June 2004 Date Added: Date(s) Discussed: October 17, 2003	FORMULARY
DX900	BLOOD GLUCOSE MONITORING SOLUTIONS	N/A	Open Formulary - no restrictions	FORMULARY
AM800	BOCEPREVIR	VICTRELIS	FORMULARY, CFU	FORMULARY
AN900	BORTEZOMIB INJ	VELCADE	Patients with stable glycemic control are limited to the following quantities of glucose test strips: patients using insulin may receive up to 300 strips per 90 days; patients using any oral agent may receive up to 50 strips per 90 days; and patients using diet or lifestyle changes may receive up to 50 strips per year. Limitations for patients without stable glycemic control will be determined by each local facility. VISN P&T Committee June 2004 Date Added: Date(s) Discussed: October 17, 2003	FORMULARY
XA502	BOTTLES/OTHER BEDSIDE URINARY COLLECTION DEVICES	N/A	Open Formulary - no restrictions	FORMULARY

IM300	BOTULISM ANTITOXIN INJ	N/A	Restrictions per local facility	FORMULARY
XA900	BOWEL MANAGEMENT TOOL	N/A	Open Formulary - no restrictions	FORMULARY
XA305	BRIEF/PANT INCONTINENCE MALE	N/A	Open Formulary - no restrictions	FORMULARY
OP900	BRIMONIDINE TARTRATE OPH SOLN	ALPHAGAN	Restricted to Ophthalmology or eye clinic	FORMULARY
AU900	BROMOCRIPTINE MESYLATE 2.5MG TAB	PARLODEL	Open Formulary - no restrictions	FORMULARY
CV702	BUMETANIDE INJ	BUMEX	Restrictions per local facility	FORMULARY
CV702	BUMETANIDE ORAL	BUMEX	Open Formulary - no restrictions	FORMULARY
CN204	BUPIVACAINE /EPINEPHRINE INJ	SENSORCAINE	Open Formulary - no restrictions	FORMULARY
CN204	BUPIVACAINE INJ	SENSORCAINE	Open Formulary - no restrictions	FORMULARY
CN204	BUPIVACAINE/DEXTROSE INJECTION	N/A	Open Formulary - no restrictions	FORMULARY
CN101	BUPRENORPHINE SL FILM	SUBOXONE	FORMULARY, CFU	FORMULARY
CN101	BUPRENORPHINE SUBLINGUAL TAB	SUBUTEX	VISN 20 Criteria for the Use of Buprenorphine Sublingual Tablets The provider must: - be a qualifying physician as defined by Drug Abuse Treatment Act 2000 (DATA) with the exception that, in the VA, individual physicians but not group practices are limited to treating 30 patients; - meet all SAMHSA and DEA notification and registration requirements for the Opioid Treatment Waiver Program PHYSICIANS (MD or DO) who are interested in obtaining a waiver may refer to: http://buprenorphine.samhsa.gov/waiver_qualifications.html AND either - have experience in addiction medicine or addiction psychiatry; OR - if inexperienced in addiction medicine, treat patients in consultation with a provider in the Physician Clinical Support System (PCSS) mentoring program	FORMULARY

(http:///www.pcssmentor.org/). (The inexperienced clinician should consult the PCSS mentor early in therapy; e.g., during the induction phase of therapy, and the PCSS provider should preferably be familiar with the VA criteria for use of sublingual buprenorphine.)

Notes
Although physicians are not required to write a valid waiver identification number on each prescription in the VA, facilities must set up a process to verify that providers are authorized to prescribe buprenorphine for treatment of opioid dependence or to restrict buprenorphine prescribing to only authorized physicians.
Physicians should refer patients to appropriate ancillary services in a timely fashion.
Nonphysicians are prohibited from prescribing buprenorphine.
It is the physician's responsibility to make sure the necessary resources (such as referrals for ancillary treatment, crosscoverage by a qualified physician, urine drug screening, and secure medication storage) are in place before prescribing buprenorphine. The physician may delegate these responsibilities to other staff members but remains responsible for assuring that appropriate clinical care is delivered.
Similarly, before converting a stable patient from methadone to buprenorphine in accordance with Patient Criterion #2, the physician should make sure a qualified physician is available to accept the patient upon the patient's transition from an OAT center to primary care or outpatient psychiatry.

			Patient Criteria: Sublingual buprenorphine is indicated for opioid agonist treatment of opioid dependence (DSM-IV diagnosis), including medically supervised withdrawal, in 1) New patients not currently receiving OAT AND who meet at least one of the following 3 criteria: - Do not have timely access to a VA-supported OAT center. - Do not meet regulatory criteria for treatment in an OAT program program. - Will have difficulty adhering to scheduled visits at a VA-supported OAT center (e.g., because of restrictive clinic hours). 2) Appropriately selected patients on stable methadone maintenance who have difficulty adhering to scheduled visits at a VA-supported OAT center or may not need close supervision. Opioid treatment programs should determine the criteria for appropriate selection of these patients, and the criteria should take into consideration such factors as the patient's psychosocial adjustment, lifestyle stability, job stability, level of physiologic opioid dependence, and need for higher doses of methadone (e.g., > 80 mg daily). 3) Patients who have a documented severe, uncontrollable adverse effect or true hypersensitivity to methadone. Uses Not Supported by Current Evidence 1) Off-label use solely for pain management 2) Use of sublingual buprenorphine primarily for analgesia in patients for whom buprenorphine was originally started for treatment of opioid dependence (DSM-IV)	

Discontinuation Criteria

1) Discontinuation as a goal of therapy: While many patients may require
long-term maintenance therapy, after a period of social, medical,
psychiatric, and substance abstinence stability, clinicians and patients
may consider a monitored taper of buprenorphine. Individual response to
therapy should determine when to attempt stopping opioid substitution
therapy.
2) Discontinuation for other reasons: Buprenorphine therapy should be
stopped if the patient:
* Misuses, abuses, or diverts buprenorphine or other controlled
prescription medications OR
* Is noncompliant with required supportive care or other ancillary
services related to therapy for opioid dependence (DSM-IV) OR
* Does not experience suppression of physiologic signs and symptoms
of withdrawal with buprenorphine 32 mg daily after the induction phase.
In this situation, buprenorphine should be stopped, the treatment plan
re-evaluated, and a more intensive level of care considered. Inadequate
response during the induction phase and failure to obtain negative urine
drug screens or abstinence should not be used as criteria for
discontinuation of buprenorphine.

Notes
In general, in the VA, methadone should remain the substitution treatment
of choice for patients needing opioid agonist maintenance therapy.
The use of buprenorphine and buprenorphine/naloxone for discontinuation
of methadone maintenance therapy may be considered on a case-by-case basis

			DATA 2000 definition of qualifying physician Physicians who satisfy conditions 1 through 3 below. 1. Meet one or more of the following training requirements: - Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties. - Hold an addiction certification from the American Society of Addiction Medicine. - Hold a subspecialty board certification in Addiction Medicine from the American Osteopathic Association. - Have completed not less than 8 hours of authorized training on the treatment or management of opioid-dependent patients. This training may include classroom situations, seminars at professional society meetings, electronic communications, or other media. The American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Medical Association, American Osteopathic Association, and the American Psychiatric Association are all authorized to provide this training. - Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary of Health and Human Services by the sponsor of such approved drug. - Have such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opioid-dependent patients.	

			- Have such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opioid-dependent patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved. - Have the capacity to provide or to refer patients for necessary ancillary services, such as psychosocial therapy. 2. Have the capacity to provide or to refer patients for necessary ancillary services, such as psychosocial therapy. 3. Agree to treat no more than 30 patients at any one time in their individual or group practice (see exceptions for VA and OAT programs in footnote below). Further information on DATA 2000 and physician qualifying requirements can be obtained at http://buprenorphine.samhsa.gov. The VA???s Centers of Excellence in Substance Abuse Treatment and Education (CESATEs) are also available for advice and consultation on buprenorphine. April 21, 2006 Date Added: April 21, 2006 Date(s) Discussed: August 21, 2003	

CN101	BUPRENORPHINE/NALOXONE	SUBOXONE	VISN 20 Criteria for the Use of Buprenorphine Sublingual Tablets The provider must: - be a qualifying physician as defined by Drug Abuse Treatment Act 2000 (DATA) with the exception that, in the VA, individual physicians but not group practices are limited to treating 30 patients; - meet all SAMHSA and DEA notification and registration requirements for the Opioid Treatment Waiver Program PHYSICIANS (MD or DO) who are interested in obtaining a waiver may refer to: http://buprenorphine.samhsa.gov/waiver_qualifications.html AND either - have experience in addiction medicine or addiction psychiatry; OR - if inexperienced in addiction medicine, treat patients in consultation with a provider in the Physician Clinical Support System (PCSS) mentoring program (http:///www.pcssmentor.org/). (The inexperienced clinician should consult the PCSS mentor early in therapy; e.g., during the induction phase of therapy, and the PCSS provider should preferably be familiar with the VA criteria for use of sublingual buprenorphine.) Notes Although physicians are not required to write a valid waiver identification number on each prescription in the VA, facilities must set up a process to verify that providers are authorized to prescribe buprenorphine for treatment of opioid dependence or to restrict	FORMULARY

			buprenorphine prescribing to only authorized physicians. Physicians should refer patients to appropriate ancillary services in a timely fashion. Nonphysicians are prohibited from prescribing buprenorphine. It is the physician's responsibility to make sure the necessary resources (such as referrals for ancillary treatment, crosscoverage by a qualified physician, urine drug screening, and secure medication storage) are in place before prescribing buprenorphine. The physician may delegate these responsibilities to other staff members but remains responsible for assuring that appropriate clinical care is delivered. Similarly, before converting a stable patient from methadone to buprenorphine in accordance with Patient Criterion #2, the physician should make sure a qualified physician is available to accept the patient upon the patient's transition from an OAT center to primary care or outpatient psychiatry. Patient Criteria: Sublingual buprenorphine is indicated for opioid agonist treatment of opioid dependence (DSM-IV diagnosis), including medically supervised withdrawal, in 1) New patients not currently receiving OAT AND who meet at least one of the following 3 criteria: - Do not have timely access to a VA-supported OAT center. - Do not meet regulatory criteria for treatment in an OAT program program. - Will have difficulty adhering to scheduled visits at a VA-supported OAT center (e.g., because of restrictive clinic hours).	

			2) Appropriately selected patients on stable methadone maintenance who have difficulty adhering to scheduled visits at a VA-supported OAT center or may not need close supervision. Opioid treatment programs should determine the criteria for appropriate selection of these patients, and the criteria should take into consideration such factors as the patient's psychosocial adjustment, lifestyle stability, job stability, level of physiologic opioid dependence, and need for higher doses of methadone (e.g., > 80 mg daily). 3) Patients who have a documented severe, uncontrollable adverse effect or true hypersensitivity to methadone. Uses Not Supported by Current Evidence 1) Off-label use solely for pain management 2) Use of sublingual buprenorphine primarily for analgesia in patients for whom buprenorphine was originally started for treatment of opioid dependence (DSM-IV) Discontinuation Criteria 1) Discontinuation as a goal of therapy: While many patients may require long-term maintenance therapy, after a period of social, medical, psychiatric, and substance abstinence stability, clinicians and patients may consider a monitored taper of buprenorphine. Individual response to therapy should determine when to attempt stopping opioid substitution therapy. 2) Discontinuation for other reasons: Buprenorphine therapy should be stopped if the patient: * Misuses, abuses, or diverts buprenorphine or other	

			controlled prescription medications OR * Is noncompliant with required supportive care or other ancillary services related to therapy for opioid dependence (DSM-IV) OR * Does not experience suppression of physiologic signs and symptoms of withdrawal with buprenorphine 32 mg daily after the induction phase. In this situation, buprenorphine should be stopped, the treatment plan re-evaluated, and a more intensive level of care considered. Inadequate response during the induction phase and failure to obtain negative urine drug screens or abstinence should not be used as criteria for discontinuation of buprenorphine. Notes In general, in the VA, methadone should remain the substitution treatment of choice for patients needing opioid agonist maintenance therapy. The use of buprenorphine and buprenorphine/naloxone for discontinuation of methadone maintenance therapy may be considered on a case-by-case basis DATA 2000 definition of qualifying physician Physicians who satisfy conditions 1 through 3 below. 1. Meet one or more of the following training requirements: - Hold a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties. - Hold an addiction certification from the American Society of Addiction Medicine. - Hold a subspecialty board certification in Addiction Medicine from the American Osteopathic Association. - Have completed not less than 8 hours of authorized	

			training on the treatment or management of opioid-dependent patients. This training may include classroom situations, seminars at professional society meetings, electronic communications, or other media. The American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Medical Association, American Osteopathic Association, and the American Psychiatric Association are all authorized to provide this training. - Have participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary of Health and Human Services by the sponsor of such approved drug. - Have such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opioid-dependent patients. - Have such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opioid-dependent patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the	

			30-day period preceding the end of the 3-year period involved. - Have the capacity to provide or to refer patients for necessary ancillary services, such as psychosocial therapy. 2. Have the capacity to provide or to refer patients for necessary ancillary services, such as psychosocial therapy. 3. Agree to treat no more than 30 patients at any one time in their individual or group practice (see exceptions for VA and OAT programs in footnote below). Further information on DATA 2000 and physician qualifying requirements can be obtained at http://buprenorphine.samhsa.gov. The VA???s Centers of Excellence in Substance Abuse Treatment and Education (CESATEs) are also available for advice and consultation on buprenorphine. April 21, 2006 Date Added: August 15, 2003 Date(s) Discussed: April 21, 2006	
CN609	BUPROPION 100MG, 150MG SA TAB	WELLBUTRIN, ZYBAN	Bupropion SR (12 hour) tablets are open formulary. November 2009 VISN 20 P&T Committee	FORMULARY
CN609	BUPROPION 75MG, 100MG TAB	WELLBUTRIN	Open Formulary - no restrictions	FORMULARY
CN309	BUSPIRONE HCL ORAL	BUSPAR	Open Formulary - no restrictions	FORMULARY
AN100	BUSULFAN ORAL AND INJ	MYLERAN	Open Formulary - no restrictions	FORMULARY
CN101	BUTORPHANOL TARTRATE INJ	STADOL	Open Formulary - no restrictions	FORMULARY
CN105	CAFFEINE/ERGOTAMINE ORAL	CAFFERGOT	Open Formulary - no restrictions	FORMULARY
CN105	CAFFEINE/ERGOTAMINE RTL SUPP	CAFFERGOT	Open Formulary - no restrictions	FORMULARY
CN809	CAFFEINE/SODIUM BENZOATE INJ	N/A	Restricted to electroconvulsive therapy Sept 2006	FORMULARY
DE900	CALAMINE LOTION (OTC)	CALAMINE	Open Formulary - no restrictions	FORMULARY
OP900	CALCIPOTRIENE TOPICAL CREAM	DOVONEX	Restricted to Dermatology Service or local facility equivalent.	FORMULARY

HS900	CALCITONIN INJ	MIACALCIN	Open Formulary - no restrictions	FORMULARY
HS900	CALCITONIN SOLN	MIACALCIN	Open Formulary - no restrictions	FORMULARY
VT502	CALCITRIOL INJ	CALCIJEX	Restrictions per local facility	FORMULARY
VT502	CALCITRIOL 0.25MCG CAP	ROCALTROL	Open Formulary - no restrictions	FORMULARY
DE820	CALCITRIOL TOPICAL OINTMENT	VECTICAL	Restricted to Dermatology Service or local facility equivalent.	FORMULARY
TN402	CALCIUM ACETATE ORAL CAPSULE	PHOSLO	Open Formulary - no restrictions	FORMULARY
TN420	CALCIUM CARBONATE (OTC) TAB	N/A	Open Formulary - no restrictions	FORMULARY
TN402	CALCIUM CARBONATE 420MG CHEW TAB	TUMS	Open Formulary - no restrictions	FORMULARY
TN402	CALCIUM CHLORIDE INJ	CALCIUM CHLORIDE	Open Formulary - no restrictions	FORMULARY
TN402	CALCIUM GLUCONATE INJ 10% 10ML	CALCIUM GLUCONATE	Open Formulary - no restrictions	FORMULARY
VT802	CALCIUM/VITAMIN D (OTC)	OSCAL	Open Formulary - no restrictions	FORMULARY
DE900	CAMPHOR 0.5%/MENTHOL 0.5% LOTION	MENTHOLATUM	Open Formulary - no restrictions	FORMULARY
DX300	CANDIDA 1:100 SKIN TEST	CANDIDA	Open Formulary - no restrictions	FORMULARY
AM500	CAPREOMYCIN INJ	CAPASTAT	Open Formulary - no restrictions	FORMULARY
DE650	CAPSAICIN 0.025% CREAM (OTC)	ZOSTRIX	Open Formulary - no restrictions	FORMULARY
DE650	CAPSAICIN 0.075% CREAM (OTC)	ZOSTRIX	Open Formulary - no restrictions	FORMULARY
CV800	CAPTOPRIL 12.5MG, 25MG, 50MG, 100MG TAB	CAPOTEN	Open Formulary - no restrictions	FORMULARY
DE400	CARA-KLENZ SKIN & WOUND CLEANSER (OTC)	CARA-KLENZ	Open Formulary - no restrictions	FORMULARY
OP102	CARBACHOL OPH SOLN	MIOSTAT	Open Formulary - no restrictions	FORMULARY
CN400	CARBAMAZEPINE 200MG TAB	TEGRETOL	Open Formulary - no restrictions	FORMULARY
CN400	CARBAMAZEPINE TAB, CHEWABLE	TEGRETOL	Restricted to patients unable to take oral tablets.	FORMULARY
OT300	CARBAMIDE PEROXIDE OTIC SOLN (OTC)	DEBROX	Open Formulary - no restrictions	FORMULARY
CN500	CARBIDOPA 10MG/LEVODOPA 100MG TAB	SINEMET	Open Formulary - no restrictions	FORMULARY
CN500	CARBIDOPA 25MG/LEVODOPA 100MG TAB	SINEMET	Open Formulary - no restrictions	FORMULARY
CN500	CARBIDOPA 25MG/LEVODOPA 250MG TAB	SINEMET	Open Formulary - no restrictions	FORMULARY
CN500	CARBIDOPA 50MG/LEVODOPA 200MG SA TAB	SINEMET CR	Restricted to Neurology Service or local equivalent	FORMULARY
AN900	CARBOPLATIN INJ	PARAPLATIN	Restrictions per local facility	FORMULARY
TN100	CARDIOPLEGIA SOLUTION 1000ML	N/A	Open Formulary - no restrictions	FORMULARY
TN100	CARDIOPLEGIA SOLUTION,ENHANCED	N/A	Open Formulary - no restrictions	FORMULARY

AN100	CARMUSTINE INJ	BICNU	Restrictions per local facility	FORMULARY
DE900	CARRINGTON DRESSING GEL TOP SPRAY (OTC)	CARRINGTON	Open Formulary - no restrictions	FORMULARY
DE900	CARRINGTON TOP GEL (OTC)	CARRINGTON	Open Formulary - no restrictions	FORMULARY
CV100	CARVEDILOL RR ORAL TAB	COREG	Open Formulary - no restrictions	FORMULARY
DE102	CASTELLANI TOP PAINT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
GA204	CASTOR OIL 60ML	N/A	Open Formulary - no restrictions	FORMULARY
XA513	CATHETER EXTERNAL W/ADHESIVE LATEX	N/A	Open Formulary - no restrictions	FORMULARY
XA513	CATHETER EXTERNAL W/ADHESIVE NON-LATEX	N/A	Open Formulary - no restrictions	FORMULARY
XA509	CATHETER STRAIGHT BALLOON 30CC	N/A	Open Formulary - no restrictions	FORMULARY
XA509	CATHETER STRAIGHT BALLOON 5CC	N/A	Open Formulary - no restrictions	FORMULARY
XA512	CATHETER STRAIGHT RUBBER	N/A	Open Formulary - no restrictions	FORMULARY
XA512	CATHETER STRAIGHT SILICONE	N/A	Open Formulary - no restrictions	FORMULARY
XA900	CATHETER SUCTION 14FR	N/A	Open Formulary - no restrictions	FORMULARY
XA510	CATHETER,COUDE-TIP	N/A	Open Formulary - no restrictions	FORMULARY
XA513	CATHETER,EXTERNAL URINARY	N/A	Open Formulary - no restrictions	FORMULARY
XA512	CATHETER,RED RUBBER	N/A	Open Formulary - no restrictions	FORMULARY
XA599	CATHETERIZATION TRAY W/CATHETER	N/A	Open Formulary - no restrictions	FORMULARY
XA599	CATHETERIZATION TRAY W/O CATHETER	N/A	Open Formulary - no restrictions	FORMULARY
AM102	CEFACLOR ORAL	CECLOR	Restricted to ID Service or local equivalent	FORMULARY
AM101	CEFAZOLIN INJ 1GM	ANCEF	Open Formulary - no restrictions	FORMULARY
AM101	CEFAZOLIN INJ 10GM	ANCEF	Open Formulary - no restrictions	FORMULARY
AM103	CEFEPIME INJ	MAXIPIME	Restrictions per local facility	FORMULARY
AM103	CEFIXIME ORAL	SUPRAX	Open Formulary - no restrictions	FORMULARY
AM103	CEFOTAXIME INJ	CLAFORAN	Restrictions per local facility	FORMULARY
AM102	CEFOTETAN INJ	CEFOTAN	Restrictions per local facility	FORMULARY
AM102	CEFOXITIN NA INJ	MEFOXIN	Restrictions per local facility	FORMULARY
AM102	CEFPODOXIME PROXETIL ORAL	VANTIN	Restricted to ID Service or local equivalent	FORMULARY
AM103	CEFTAZIDIME INJ	FORTAZ	Restrictions per local facility	FORMULARY
AM117	CEFTIZOXIME	CEFIZOX	Restrictions per local facility	FORMULARY

AM103	CEFTRIAXONE NA INJ	ROCEPHIN	Restrictions per local facility	FORMULARY
AM102	CEFUROXIME AXETIL ORAL	CEFTIN	Restricted to ID Service or local equivalent	FORMULARY
AM101	CEPHALEXIN ORAL	KEFLEX	Open Formulary - no restrictions	FORMULARY
AH500	CETIRIZINE ORAL	ZYRTEC	Open Formulary - no restrictions	FORMULARY
AD900	CHARCOAL ACTIVATED IN SORBITOL LIQUID (OTC)	CHARCOAL	Open Formulary - no restrictions	FORMULARY
AD900	CHARCOAL ACTIVATED LIQUID (OTC)	CHARCOAL	Open Formulary - no restrictions	FORMULARY
XA100	CHEMO SPILL KIT	N/A	Open Formulary - no restrictions	FORMULARY
CN309	CHLORAL HYDRATE 500MG CAP	NOCTEC	Restricted to sleep/EEG studies	FORMULARY
CN309	CHLORAL HYDRATE SYRUP	N/A	Restricted to sleep/EEG studies	FORMULARY
AN100	CHLORAMBUCIL ORAL	LEUKARAN	Restricted to Oncology Service or local equivalent	FORMULARY
AM150	CHLORAMPHENICOL INJ	CHLOROMYCETIN	Restrictions per local facility	FORMULARY
OP201	CHLORAMPHENICOL OPH SOLN	CHLOROPTIC	Open Formulary - no restrictions	FORMULARY
CN302	CHLORDIAZEPOXIDE 10MG, 25MG CAP	LIBRIUM	Open Formulary - no restrictions	FORMULARY
OR400	CHLORHEXIDINE GLUCONATE 0.12% ALCOHOL-FREE MOUTH RINSE	N/A	Open Formulary - no restrictions	FORMULARY
OR500	CHLORHEXIDINE GLUCONATE ORAL RINSE	PERIDEX	Open Formulary - no restrictions	FORMULARY
DE101	CHLORHEXIDINE GLUCONATE SURGICAL SCRUB (OTC)	HIBICLENS	Open Formulary - no restrictions	FORMULARY
DE101	CHLORHEXIDINE GLUCONATE TOP LIQUID (OTC)	HIBICLENS	Open Formulary - no restrictions	FORMULARY
DE900	CHLOROPHYLL/PAPAIN/UREA OINT	PANAFIL, ZIOX	Restricted to Dermatology or local equivalent	FORMULARY
AH400	CHLORPHENIRAMINE MALEATE 4MG TAB	CHLOR-TRIMETON	Open Formulary - no restrictions	FORMULARY
AH400	CHLORPHENIRAMINE MALEATE SA TAB (OTC)	CHLOR-TRIMETON	Open Formulary - no restrictions	FORMULARY
CN204	CHLORPROCAINE HCL INJ	NESACAINE	Open Formulary - no restrictions	FORMULARY
CN701	CHLORPROMAZINE 10MG TAB	THORAZINE	Open Formulary - no restrictions	FORMULARY
CN701	CHLORPROMAZINE HCL 25, 50, 100, 200MG TAB	THORAZINE	Open Formulary - no restrictions	FORMULARY
CN701	CHLORPROMAZINE INJ 25MG/ML 2ML	THORAZINE	Open Formulary - no restrictions	FORMULARY
CN701	CHLORPROMAZINE ORAL CONC 30MG/ML	THORAZINE	Open Formulary - no restrictions	FORMULARY
CN701	CHLORPROMAZINE ORAL CONC 100MG/ML	THORAZINE	Open Formulary - no restrictions	FORMULARY
CN701	CHLORPROMAZINE SYRUP 10MG/5ML	THORAZINE	Open Formulary - no restrictions	FORMULARY

CV701	CHLORTHALIDONE ORAL	HYGROTON	Open Formulary - no restrictions	FORMULARY
CV350	CHOLESTYRAMINE 4GM/9GM ORAL PWD	QUESTRAN	Cholestyramine oral powder is Open Formulary - the first line bile resin binding agent; Colestipol powder is second line to cholestyramine for inadequate therapeutic effect or intolerable side effects from generic cholestyramine; Colestipol tablets are third line. April 2004, Sept 2006 VISN 20 P&T Committee Date Added: April 16, 2004 Date(s) Discussed: August 19, 2005	FORMULARY
OP900	CHONDROITIN / HYALURONATE OPHTHALMIC INJECTION	N/A	Open Formulary - no restrictions	FORMULARY
TN499	CHROMIUM INJ	N/A	Restrictions per local facility	FORMULARY
AM800	CIDOFOVIR INJ	VISTIDE	Restricted to HIV prescribers	FORMULARY
AM130	CILASTATIN NA/IMIPENEM INJ	PRIMAXIN	Restrictions per local facility	FORMULARY
GA301	CIMETIDINE 300MG,400MG TAB	TAGAMET	Open Formulary - no restrictions	FORMULARY
GA301	CIMETIDINE ELIXIR 300MG/5ML	TAGAMET	Open Formulary - no restrictions	FORMULARY
GA301	CIMETIDINE HCL INJ	TAGAMET	Open Formulary - no restrictions	FORMULARY
OP201	CIPROFLOXACIN HCL OPH SOLN	CIPRO	Restricted to Ophthalmology or eye clinic	FORMULARY
AM900	CIPROFLOXACIN HCL REGULAR RELEASE ORAL TAB	CIPRO	Open Formulary - no restrictions	FORMULARY
AM900	CIPROFLOXACIN INJ	CIPRO	Restrictions per local facility	FORMULARY
MS300	CISATRACURIUM BESYLATE INJ	NIMBEX	Restrictions per local facility	FORMULARY
AN900	CISPLATIN INJ	PLATINOL	Restrictions per local facility	FORMULARY
CN609	CITALOPRAM ORAL	CELEXA	Sertraline, fluoxetine and citalopram are first line SSRIs. April 2007	FORMULARY
IR100	CITRIC ACID/GLUCONO-DELTA/LACTONE/MAGNESIUM CARBON	N/A	Open Formulary - no restrictions	FORMULARY

TN410	CITRIC ACID/K CITRATE/NA CITRATE SYRUP	POLYCITRA	Open Formulary - no restrictions	FORMULARY
IR100	CITRIC ACID/MAGNESIUM OXIDE/SODIUM CARBONATE SOLN	SOLU G UROLOGICAL IRRIGATING SOLN	Open Formulary - no restrictions	FORMULARY
TN410	CITRIC ACID/NA CITRATE ORAL SOLN	BICITRA	Open Formulary - no restrictions	FORMULARY
TN478	CITRIC ACID/POTASSIUM CITRATE ORAL POWDER	CYTRA-K, POLYCITRA-K	Open Formulary - no restrictions	FORMULARY
TN478	CITRIC ACID/POTASSIUM CITRATE ORAL SOLUTION	N/A	Open Formulary - no restrictions	FORMULARY
AN300	CLADRIBINE INJ	LEUSTATIN	Restrictions per local facility	FORMULARY
XA599	CLAMP CUNNINGHAM REGULAR	CUNNINGHAM	Open Formulary - no restrictions	FORMULARY
XA699	CLAMP,BAG (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA599	CLAMP,CUNNINGHAM (OTC)	CUNNINGHAM	Open Formulary - no restrictions	FORMULARY
AM200	CLARITHROMYCIN ORAL	BIAXIN	Restricted to ID Service or local equivalent	FORMULARY
CV805	CLASS REVIEW: ANGIOTENSIN II INHIBITORS	N/A	Open Formulary - no restrictions	FORMULARY
RE109	CLASS REVIEW: ANTIASTHMA,OTHER-INCLUDING LEUKOTRIE	N/A	Restrictions per local facility	FORMULARY
NT200	CLASS REVIEW: ANTI-INFLAMMATORIES,NASAL	N/A	Restrictions per local facility	FORMULARY
RE103	CLASS REVIEW: BRONCHODILATORS,SYMPATHOMIMETIC,ORAL	N/A	Restrictions per local facility	FORMULARY
HS900	CLASS REVIEW: HORMONES/MODIFIERS/OTHER	N/A	Open Formulary - no restrictions	FORMULARY
DX102	CLASS REVIEW: IONIC CONTRAST MEDIA	N/A	Open Formulary - no restrictions	FORMULARY
DX101	CLASS REVIEW: NON-IONIC CONTRAST MEDIA	N/A	Open Formulary - no restrictions	FORMULARY
AM350	CLINDAMYCIN HCL 150MG, 300MG CAP	CLEOCIN	Open Formulary - no restrictions	FORMULARY
AM350	CLINDAMYCIN ORAL SUSP 75MG/5ML	CLEOCIN	Open Formulary - no restrictions	FORMULARY
GU300	CLINDAMYCIN PHOSPHATE VAG CREAM	CLEOCIN	Open Formulary - no restrictions	FORMULARY
AM350	CLINDAMYCIN PHOSPHATE INJ	CLEOCIN	Open Formulary - no restrictions	FORMULARY
DE752	CLINDAMYCIN TOPICAL SOLN 1% 60ML	CLEOCIN	Open Formulary - no restrictions	FORMULARY
RE109	CLOBETASOL PROP CREAM	TEMOVATE	Open Formulary - no restrictions	FORMULARY
DE200	CLOBETASOL PROPIONATE 0.05% OINT	TEMOVATE	Open Formulary - no restrictions	FORMULARY
DE200	CLOBETASOL PROPIONATE 0.05% TOP SOLN	TEMOVATE	Open Formulary - no restrictions	FORMULARY
HS400	CLOMIPHENE CITRATE 50MG TAB	CLOMID	Restricted to Women's Health providers or local facility equivalent.	FORMULARY

CN601	CLOMIPRAMINE ORAL	ANAFRANIL	Open Formulary - no restrictions	FORMULARY
CN400	CLONAZEPAM ORAL	KLONOPIN	Open Formulary - no restrictions	FORMULARY
CV490	CLONIDINE PATCH	CATAPRES	Restricted to treatment of HTN or smoking cessation programs	FORMULARY
CV490	CLONIDINE HCL 0.1MG, 0.2MG TAB	CATAPRESS	Open Formulary - no restrictions	FORMULARY
CN103	CLONIDINE PF INJ	DURACLON	Clonidine PF injection for intrathecal use is restricted to VA Anesthesiology and VA Pain Service. Intrathecal agents should be marked as preservative-free/FT in local facility drug files. Feb 2007 VISN 20 P&T Committee	FORMULARY
BL700	CLOPIDOGREL ORAL	PLAVIX	Clopidogrel (Plavix) Criteria for Use in Veteran Patients VHA Pharmacy Benefits Management Services and the Medical Advisory Panel The following recommendations are based on medical evidence, clinician input, and expert opinion. The content of the document is dynamic and will be revised as new information becomes available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. The clinician should utilize this guidance and interpret it in the clinical context of the individual patient. Individual cases that are outside the recommendations should be adjudicated at the local facility according to the policy and procedures of its P&T Committee and Pharmacy Services Exclusion Criteria O Substantial risk of bleeding O Known hypersensitivity to clopidogrel or any component of the product Inclusion Criteria- one of the following indications is	FORMULARY

required

O Post percutaneous coronary intervention (PCI)/stent
O NSTEMI/Unstable angina acute coronary syndromes
O STEMI /acute coronary syndrome
O Coronary Artery Bypass Grafting (CABG)
O Cerebral ischemic events*
O Non-cardiac stenting
O Need for antiplatelet therapy but has a true aspirin allergy (ie;
anaphylaxis or aspirin induced asthma) or extended release aspirin
dipyridamole therapy induced headaches

Duration- please refer to Table 1(enter duration after indication)

O Post PCI/ bare metal stent _____
O Post PCI / DES stent_____
O NSTEMI/Unstable angina acute coronary syndromes _____
O STEMI /acute coronary syndrome _____
O Elective Coronary Artery Bypass Grafting (CABG) _____
O Brachytherapy _____
O Cerebral ischemic events _____
O Non-cardiac stenting _____
O Other_____

Monitoring

Patients should be followed for development of neutropenia and/or
thrombotic thrombocytopenic purpura

Routine use of platelet function assays to monitor the antithrombotic
effect of aspirin or clopidogrel is not recommended

* Clopidogrel therapy for a cerebral ischemia indication should be
monotherapy only. Clopidogrel should not be combined with aspirin
for this indication

TABLE ONE: Clopidogrel dose and duration by

indication

clopidogrel dose duration (strong evidence support)
aspirin allergy (Anaphylaxis, aspirin induced asthma)
75 mg daily indefinite (for as long as
antiplatelet therapy is required)
bare metal stent 300-600 mg load,
then 75 mg daily for at least one month, ideally up
to 12 months
DES-uncomplicated 300-600 mg load, then 75 mg daily
12 months
DES complex anatomy* 300-600 mg load, then 75 mg
daily 12 months,
longer duration may be considered
in absence of bleeding risk factors
DES-history of stent thrombosis
300-600 mg load, then 75 mg daily
give combination of aspirin
clopidogrel indefinitely in
absence of bleeding risk factors
ACS (no stent) 300-600 mg load, then 75 mg daily 12
months
NSTEMI/ACS (no stent) 75 mg daily 12 months
NSTE ACS then CABG 75 mg daily 9-12 months post
procedure
STEMI/MI (no stent) 300 mg load for patients < 75 yrs
and 75 mg for > 75
years if they receive fibrinolytics, then 75 mg
daily for at least 14 days and up to 12 months

cerebral ischemia 75 mg daily indefinite- do not give
aspirin and
clopidogrel together
brachytherapy 75 mg daily indefinite
intracranial stent 75 mg daily 3 months up to 1 year
extracranial stent# 75 mg daily 6 weeks
renal stent 75 mg daily up to 12 months
peripheral (inguinal, popliteal) stent
75 mg daily 30 days

Background and Evidence for Clopidogrel (Plavix)
Criteria for Use
VHA Pharmacy Benefits Management Services and the
Medical Advisory Panel

Recommendations for use of clopidogrel post
percutaneous coronary

			intervention (PCI)/stent Patients who receive coronary stents will require dual anti-platelet therapy with aspirin and clopidogrel in order to maintain patency of the artery. There is evidence that drug eluting stents (DES) may confer a rare but increased risk of late stent thrombosis in certain patient populations (including complex coronary anatomy such as: left main DES, DES of bifurcations, overlapping DES, prior history of late stent thrombosis, and DES of bypass graft), suggesting a longer duration of dual therapy may be needed. The exact duration of clopidogrel therapy in these situations has not been conclusively established, however when making this determination providers must weigh the benefit of prolonged or indefinite clopidogrel therapy against the risk for bleeding on a patient by patient basis Retrospective data supports that the most vulnerable period may be 0 to 90 days after discontinuation of clopidogrel. It has not been clearly defined if the use of a tapering schedule for discontinuation may alleviate this response. The optimal dose of aspirin remains controversial. There is no convincing evidence from randomized studies that have compared different doses of aspirin that higher doses are more effective in reducing the risk of serious vascular events. Higher doses of aspirin are associated with increased bleeding risk. Data emerging from pooled meta-analyses and registries suggest the need for uninterrupted dual antiplatelet therapy throughout the post-stenting treatment period. Any elective procedures which would	

require stopping or interrupting this therapy (dental work, colonoscopy,
etc.) should be delayed until the minimum treatment duration based on
stent type is completed.

Recommendations for use of clopidogrel in NSTEMI/Unstable angina acute
coronary syndromes

In patients with acute coronary syndrome and /or unstable angina
in whom no revascularization procedure is planned, clopidogrel should be
added to aspirin as soon as possible.

Recommendations for use of clopidogrel in STEMI acute coronary syndrome

In patients with STEMI < 75 years of age receiving fibrinolytics,
clopidogrel should be administered as a 300mg loading dose followed by
75mg once daily until hospital discharge (up to 8 days) or longer if
undergoing angiography/coronary intervention as described in
recommendations post PCI/Stent.
In patients of any age with STEMI regardless of whether
fibrinolytics are utilized clopidogrel should be administered at a dose
of 75mg once daily until hospital discharge or up to 4 weeks or longer if
undergoing angiography/coronary intervention as described in
recommendations post PCI/Stent.
In patients with STEMI who do not undergo PCI consideration may
be given to continuing clopidogrel 75mg once daily for up to 1-year based
on extrapolation from trials in NSTEMI/Unstable angina.

Recommendations for use of clopidogrel in stable coronary artery disease
(CAD)

There is insufficient evidence to recommend initiation in those
patients with stable CAD and who do not meet criteria in this document.

Recommendations for use of clopidogrel in aspirin adverse events

Clopidogrel should be used in patients who are aspirin allergic,
i.e.; anaphylaxis, aspirin induced bronchospasm. (Level A)
In patients with a history of gastrointestinal complications from
aspirin (i.e.; bleeding, stomach upset), adding a proton pump inhibitor
to aspirin therapy is preferred.

Recommendations for use of concurrent clopidogrel and proton pump
inhibitor therapy

Recent evidence suggests that genetic variables may be important
in the metabolism/activation of clopidogrel. Early trials suggest a link
between the cytochrome P450 system, especially the 2C19 isoenzyme and
clopidogrel response.
It is possible that patients with a decrease in 2C19 isoenzyme
may not display an expected response to clopidogrel. Additionally, proton
pump inhibitors (metabolized by the 2C19 isoenzyme) may alter a patient's
response to clopidogrel.
A nested case control study by Juurlink et, al demonstrated that
combined therapy with clopidogrel and a PPI increased the risk of
reinfarction, with an adjusted odds ratio 1.27 with a CI of 1.03-1.57.
A retrospective cohort study of 8205 patients with ACS taking
clopidogrel after discharge from 127 Veterans Affairs hospitals between
October 1, 2003, and January 31, 2006. reported that

			patients taking clopidogrel after hospital discharge and prescribed PPI at any point during follow-up (n = 5244), periods of use of clopidogrel plus PPI (compared with periods of use of clopidogrel without PPI) were associated with a higher risk of death or rehospitalization for ACS (adjusted hazard ratio, 1.27; 95% CI, 1.10-1.46). following coronary stenting over 12 months: In a nationally representative, claims-based, observational study of 16,690 patients adherent and persistent to clopidogrel therapy was associated with a 51% greater risk of a CV event than clopidogrel alone. It does not appear that a single PPI is less likely than others to result in the potential interaction. Omperazole, esomeprazole, pantoprazole and lansoprazole were each associated with 39-61% greater risk of a CV event vs. clopidogrel alone. The FDA has issued a safety bulletin regarding this issue and is working with manufacturers to design a prospective trial to assess the interaction. Patients who are currently receiving therapy with a PPI and clopidogrel should be evaluated for the continued need for PPI therapy.. Recommendations on the use of dual antiplatelet therapy versus warfarin therapy in atrial fibrillation The ACTIVE-W trial was a comparison of warfarin with the combination of clopidogrel and aspirin in patients with atrial fibrillation. The results of ACTIVE-W demonstrated that use of a vitamin-K antagonist reduced the risk for stroke by 42% over clopidogrel	

and aspirin.
The ACTIVE A trial enrolled patients who were considered
unsuitable for warfarin therapy. These patients were then randomized to
clopidogrel/aspirin vs. aspirin only. The reasons for not being an
appropriate warfarin candidate were varied, and included poor control of
the INR, multiple drug interactions, warfarin allergy and/or patient
preference.
The number needed to treat (NNT) from the ACTIVE-A trial is 111
(clopidogrel/aspirin vs. aspirin alone) this is in comparison to NNTs of
20-30 for trials evaluating stroke reduction in patients receiving
warfarin vs. control from SPAF-1, SPINAF trials.
Compared with aspirin alone, the combination of clopidogrel and
aspirin in patients unsuitable for warfarin therapy reduces the risk of
major vascular events but does so at an increased risk for major
bleeding. The absolute difference for the reduction of major vascular
events between the study treatment groups, is about 0.8% per year, and
compares with the major bleeding rate, which is 0.7% per year.
Those patients who are excluded from warfarin therapy due to
excessive bleeding risk may have the same elevated bleeding risk with
dual antiplatelet therapy (see ACTIVE W trial).
Patients who should not be considered for dual antiplatelet
therapy include low risk for thromboembolic disease, documented PUD
within the previous 6 months, history of intracerebral hemorrhage,
significant thrombocytopenia, or ongoing alcohol abuse.
Frequently patients who are not felt to be candidates for

warfarin therapy at one point in time may no longer have the same

			contraindications at a later date. These patients should be re-evaluated every 6 months to insure that ongoing use of dual antiplatelet therapy is appropriate. Recommendations for the use of clopidogrel in Peripheral Vascular Disease (PVD) Clopidogrel is not recommended for PVD except in cases of aspirin allergy. Recommendations for the use of clopidogrel in noncardiac stenting Patients who undergo carotid artery stenting may be initiated on clopidogrel 75 mg/day and continued for 4-6 weeks post stent. Patients who undergo intracranial stents may require longer durations of therapy and can be continued up to 1 year. Patients who undergo renal artery stenting may be initiated on clopidogrel 75 mg daily for up to 12 months post intervention. Patients who undergo other peripheral stents (inguinal, popliteal, etc) may be continued on clopidogrel 75 mg daily for 30 days post intervention. Recommendations for the use of clopidogrel in recurrent cerebral ischemic events Patients with recurrence of cerebral ischemic events while on therapy with aspirin should be changed to an alternate antiplatelet agent. Both clopidogrel and extended release dipyridamole/aspirin have been proven superior to aspirin in separate trials. Extended release dipyridamole/aspirin was not able to demonstrate

noninferiority to clopidogrel in a randomized, double blinded trial of
stroke patients. The findings of the PRoFESS trial demonstrated a lack of
evidence that either of the two treatments were superior to the other in
prevention of recurrent stroke.
Clopidogrel is an alternative for those patients who have had
recurrent cerebrovascular events, who have a documented aspirin allergy,
as mentioned above or are intolerant of extended release aspirin/
dipyridamole (recurrent headache).
The combination of aspirin and clopidogrel is not advised for
secondary stroke prophylaxis due to increased risk of adverse events
demonstrated in the MATCH trial.

Alternate dosing regimens for clopidogrel

The question of increased dosing with clopidogrel in treatment refractory
patients has been discussed. A clinical trial in Type 2 diabetes mellitus
patients investigated the efficacy of BID dosing. They demonstrated that
increasing the dose of clopidogrel to 150 mg per day is associated with
enhanced antiplatelet effects as measured by platelet aggregation
studies. These studies were not correlated to any clinical outcomes. In
a previous AHA/ACC guidelines, the use of a clopidogrel 150mg per day is
recommended if there is less than 50% inhibition of platelet aggregation
or if the risk of subacute thrombosis would be catastrophic or lethal
(unprotected left main, bifurcating left main or last patent coronary
vessel, or patient who has survived an in-stent thrombosis despite
compliance with clopidogrel 75mg daily). However, these same guidelines
recommend against using platelet reactivity testing on a

			routine basis. VA MAP/PBM August 2009; VISN 20 P&T October 2009 Date Added: September 18, 1998 Date(s) Discussed: July 21, 2000 February 15, 2002	
DE102	CLOTRIMAZOLE 1% TOP SOLN	MYCELEX	Open Formulary - no restrictions	FORMULARY
NT900	CLOTRIMAZOLE 10MG TROCHE	MYCELEX	Open Formulary - no restrictions	FORMULARY
DE102	CLOTRIMAZOLE CREAM 1% 30GM	MYCELEX	Open Formulary - no restrictions	FORMULARY
GU300	CLOTRIMAZOLE VAG CREAM (OTC)	MYCELEX	Open Formulary - no restrictions	FORMULARY
CN709	CLOZAPINE ORAL	CLOZARIL	VISN 20 Guidelines for Atypical Antipsychotics Atypical antipsychotics are restricted to the treatment of first episode psychosis or chronic psychosis in relapse. (national guidelines) First (and 2nd) line atypical antipsychotics: (alphabetical, no prescribed hierarchy) Aripiprazole Quetiapine Risperidone Ziprasidone 3rd line Olanzapine Clozapine (if poor response to AT LEAST 2 other atypical antipchotics) April 2007 VISN 20 P&T Committee VISN 20 Guidelines for Screening and Monitoring Patients Prescribed Atypical Antipsychotics Baseline Screening Guidelines Prior to initiating a new atypical antipsychotic, it is	FORMULARY

			recommended that clinicians: 1. Obtain/review the patient's personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease. 2. Provide basic education about signs and symptoms of Hyperglycemia Diabetic ketoacidosis 3. Obtain or document in CPRS baseline measures for Fasting lipid panel and fasting blood sugar (or an HgA1C if it is difficult to get the patient's cooperation for a fasting blood sugar) Weight (entered into CPRS Cover Sheet) Height (entered into CPRS Cover Sheet) Blood pressure (entered into CPRS Cover Sheet) Subsequent Monitoring Guidelines During the first 4 months of treatment, it is recommended that clinicians: 1. Obtain a fasting blood sugar and lipid panel at least once. 2. Record weight at each visit; note any increases. 3. Record blood pressure at least once. At one year of treatment, it is recommended that clinicians: 1. Make sure that a recent weight and blood pressure are recorded in the chart. 2. Repeat fasting glucose. 3. Order a lipid panel if there are concerns about significant weight gain, personal or family risk factors for cardiovascular disease, or past abnormal laboratory results. After one year, monitoring is at the clinician's discretion. Considerations that would warrant further annual or	

			more frequent screening include: 1. Significant amount of weight gain or pre-existing obesity 2. Family or personal history of other significant risk factors for cardiovascular disease or diabetes 3. Past abnormal laboratory screening results Summary of VISN 20 Screening and Monitoring Recommendations Measure Baseline First 4 Months One Year Personal/Family History Yes Review any changes Patient/Family Education Yes Height Yes Weight (BMI) Yes Each visit Yes Fasting glucose/ Hgb A1c Yes At least once Yes Fasting lipid profile Yes At least once If clinically indicated Blood pressure Yes At least once Yes June 2005 VISN 20 P&T	
DE802	COAL TAR 0.5/%SAL AC 2%/SULFUR 2% SHAMPOO (OTC)	SEBULEX	Open Formulary - no restrictions	FORMULARY
DE802	COAL TAR 10%/SALICYLIC ACID 4% SHAMPOO (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE802	COAL TAR 2% OINT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE802	COAL TAR 2.5% TOP SOLN (OTC)	BALNETAR	Open Formulary - no restrictions	FORMULARY
DE802	COAL TAR 5%/SALICYCLIC ACID 2%/SULFUR 2% SHAMPOO (	SEBUTONE	Open Formulary - no restrictions	FORMULARY
DE802	COAL TAR 8.75% SHAMPOO (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE802	COAL TAR SHAMPOO 1% 180ML (OTC)	POLYTAR	Open Formulary - no restrictions	FORMULARY
NT300	COCAINE 4% TOPICAL SOLN 4ML	N/A	Open Formulary - no restrictions	FORMULARY
DX300	COCCIDIOIDIN INJ 1:100 1ML	N/A	Open Formulary - no restrictions	FORMULARY
CN101	CODEINE SULFATE 30MG TAB	CODEINE	Open Formulary - no restrictions	FORMULARY

RE301	CODEINE/GUAIFENESIN SYRUP	ROBITUSSIN AC	Restricted to failure on dextromethorphan/ guaifenesin, individual drugs, and benzonatate	FORMULARY
MS400	COLCHICINE 0.6MG TAB	COLCHICINE	Open Formulary - no restrictions	FORMULARY
CV350	COLESTIPOL GRANULES	COLESTID	Cholestyramine oral powder is Open Formulary - the first line bile resin binding agent; Colestipol powder is second line to cholestyramine for inadequate therapeutic effect or intolerable side effects from generic cholestyramine; Colestipol tablets are third line. April 2004, Sept 2006 VISN 20 P&T Committee Date Added: Date(s) Discussed: April 16, 2004	FORMULARY
CV350	COLESTIPOL ORAL PWD 500GM	COLESTID	Cholestyramine oral powder is Open Formulary - the first line bile resin binding agent; Colestipol powder is second line to cholestyramine for inadequate therapeutic effect or intolerable side effects from generic cholestyramine; Colestipol tablets are third line. April 2004, Sept 2006 VISN 20 P&T Committee	FORMULARY
CV350	COLESTIPOL ORAL TAB	COLESTID	Cholestyramine oral powder is Open Formulary - the first line bile resin binding agent; Colestipol powder is second line to cholestyramine for inadequate therapeutic effect or intolerable side effects from generic cholestyramine; Colestipol tablets are third line. April 2004, Sept 2006 VISN 20 P&T Committee	FORMULARY
DE900	COLLAGENASE TOP OINT	SANTYL	Restricted to Dermatology or local equivalent	FORMULARY
XA602	COLLAR,TAN,SUR-FIT FLEX C#0225-21 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	COLLAR,TAN,SUR-FIT FLEX C#0225-22 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	COLLAR,TAN,SUR-FIT FLEX C#0225-23 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA604	COMPOUND BENZOIN TINCTURE,TOP (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	CONDOM FEMALE	N/A	Open Formulary - no restrictions	FORMULARY
XA900	CONDOM LATEX LUBRICATED	N/A	Open Formulary - no restrictions	FORMULARY

XA900	CONDOM LATEX PLAIN	N/A	Open Formulary - no restrictions	FORMULARY
HS900	CONJUGATED ESTROGENS 0.3MG/1.5MG MEDROXYPROGESTERONE	PREMPRO 0.3 MG/ 1.5MG	Open Formulary - no restrictions	FORMULARY
HS900	CONJUGATED ESTROGENS 0.45MG/1.5MG MEDROXYPROGESTERONE	PREMPRO	Open Formulary - no restrictions	FORMULARY
HS900	CONJUGATED ESTROGENS 0.625MG/2.5MG MEDROXYPROGEST	PREMPRO	Open Formulary - no restrictions	FORMULARY
HS900	CONJUGATED ESTROGENS 0.625MG/5MG MEDROXYPROGESTERO	PREMPRO	Open Formulary - no restrictions	FORMULARY
HS900	CONJUGATED ESTROGENS/PROGESTERONE TAB	PREMPHASE	Restricted to Women's Health providers or local facility equivalent.	FORMULARY
XA602	CONVEX INSERT ID 1 - 1 3/8	N/A	Open Formulary - no restrictions	FORMULARY
XA602	CONVEX INSERT,SUR-FIT C#1850-12 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	CONVEX INSERT,SUR-FIT C#1850-15 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	CONVEX INSERT,SUR-FIT C#1850-16 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	CONVEX INSERT,SUR-FIT C#1850-17 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA602	CONVEX INSERT,SUR-FIT C#1850-20 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
TN499	COPPER INJ	N/A	Restrictions per local facility	FORMULARY
HS701	CORTICOTROPIN INJ	ACTHAR	Open Formulary - no restrictions	FORMULARY
DX900	COSYNTROPIN INJ	CORTROSYN	Open Formulary - no restrictions	FORMULARY
XA900	COTTON BALLS EA.	N/A	Open Formulary - no restrictions	FORMULARY
XA900	COTTON-TIP APPLICATOR NONSTERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	COTTON-TIP APPLICATOR STERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
OP900	CROMOLYN SODIUM OPH SOLN	INTAL	Open Formulary - no restrictions	FORMULARY
IM900	CROMOLYN SODIUM ORAL	INTAL	Open Formulary - no restrictions	FORMULARY
RE109	CROMOLYN SODIUM SOLN, INHL	N/A	Restricted to patients unable to utilize oral inhaler	FORMULARY
NT900	CROMOLYN SODIUM SOLN, NASAL	N/A	Open Formulary - no restrictions	FORMULARY
DE900	CURAFIL WOUND DRESSING TOPICAL GEL	CURAFIL	Open Formulary - no restrictions	FORMULARY
AD200	CYANIDE ANTIDOTE PACKAGE INJ	CYANIDE	Open Formulary - no restrictions	FORMULARY
VT101	CYANOCOBALAMIN 1000MCG TAB	REDISOL	Open Formulary - no restrictions	FORMULARY
VT101	CYANOCOBALAMIN 1000MCG/ML INJ	REDISOL	Open Formulary - no restrictions	FORMULARY
MS200	CYCLOBENZAPRINE ORAL	FLEXERIL	Open Formulary - no restrictions	FORMULARY

OP600	CYCLOPENTOLATE HCL OPH SOLN	CYCLOGYL	Open Formulary - no restrictions	FORMULARY
OP600	CYCLOPENTOLATE/PHENYLEPHRINE 1%/2.5% OPH	CYCLOMYDRIL	Open Formulary - no restrictions	FORMULARY
AN100	CYCLOPHOSPHAMIDE INJ	CYTOXAN	Restrictions per local facility	FORMULARY
AN100	CYCLOPHOSPHAMIDE ORAL	CYTOXAN	Open Formulary - no restrictions	FORMULARY
AM500	CYCLOSERINE ORAL	SEROMYCIN	Open Formulary - no restrictions	FORMULARY
IM600	CYCLOSPORINE 25MG CAP (GENGRAF BRAND IS PREFERRED)	GENGRAF	Cyclosporine is formulary, restricted to cardiology, nephrology, dermatology, and transplant services or local facility equivalent. June 2009	FORMULARY
IM600	CYCLOSPORINE 0.05% OPHTHALMIC SUSPENSION	RESTASIS	FORMULARY, CFU RESTRICTED TO OPTOMETRY AND OPHTHALMOLOGY	FORMULARY
IM600	CYCLOSPORINE 100MG CAP (GENGRAF BRAND IS PREFERRED)	GENGRAF	Cyclosporine is formulary, restricted to cardiology, nephrology, dermatology, and transplant services or local facility equivalent. June 2009	FORMULARY
IM600	CYCLOSPORINE INJ	SANDIMMUNE	Restrictions per local facility	FORMULARY
IM600	CYCLOSPORINE ORAL SOLN 100MG/ML	SANDIMMUNE	Cyclosporine is formulary, restricted to cardiology, nephrology, dermatology, and transplant services or local facility equivalent. June 2009	FORMULARY
AH700	CYPROHEPTADINE HCL 4MG TAB	PERIACTIN	Open Formulary - no restrictions	FORMULARY
AN300	CYTARABINE INJ	CYTOSAR U	Restrictions per local facility	FORMULARY
IM500	CYTOMEGALOVIRUS IMMUNE GLOBULIN HUMAN	CYTOGAM	Open Formulary - no restrictions	FORMULARY
BL110	DABIGATRAN	PRADAXA	FORMULARY,CFU	FORMULARY
AN900	DACARBAZINE INJ	DTIC	Restrictions per local facility	FORMULARY
IM600	DACLIZUMAB INJ	ZENAPAX	Restricted to transplant services or local equivalent.	FORMULARY
AN200	DACTINOMYCIN INJ	COSMEGEN	Restrictions per local facility	FORMULARY

AM900	DALFOPRISTIN / QUINUPRISTIN INJ (SYNERCID)	SYNERCID	Restriction Criteria (below): Recommendation of Use for Quinupristin-dalfopristin (Synercid) JUNE 2009 Pharmacy Benefits Management Service and the Medical Advisory Panel FDA APPROVED INDICATION(S) FOR USE - Complicated skin and skin structure infections caused by Staphylococcus aureus and Streptococcus pyogenes - Serious or life-threatening infections associated with vancomycin-resistant Enterococcus faecium bacteremia EXCLUSION CRITERIA (If one is selected, patient is NOT eligible) - Clinical evaluation of patient with positive microbiology culture(s) is consistent with colonization (not active infection). - Known resistance to quinupristin-dalfopristin. - Treatment for infection caused by E. faecalis. Contraindications: - Known hypersensitivity to streptogramins. - Co-administration of medications metabolized by the cytochrome P450 3A4 that may prolong QTc interval. INCLUSION CRITERIA (If one is selected, patient is eligible) - Documented vancomycin and ampicillin resistant E. faecium infection in a patient who is intolerant or failed linezolid. July 2009 VISN 20 P&T . Date Added: February 18, 2000 Date(s) Discussed: August 18, 2000 September 15, 2006	FORMULARY
BL100	DALTEPARIN INJ	FRAGMIN	VISN 20 Low Molecular Weight Heparin (LMWH)	FORMULARY

Criteria - November 2004

Dalteparin is available for patients allergic to enoxaparin.
Enoxaparin is available for patients allergic to dalteparin.

1. When enoxaparin and dalteparin are dosed once a day, the cost of
these agents is similar and either agent can be used.

2. Dalteparin is the preferred agent for situations in which
enoxaparin would be dosed more than once a day, except for patients with
unstable angina and non-Q-wave myocardial infarction or who are allergic
to dalteparin.

Each indication below lists the agents, recommended dosage regimens, and
costs as of Nov 2004:

Approved Indications:

a. DVT/PE prophylaxis for perioperative patients undergoing hip and
knee replacement/surgery. Appropriate follow-up and monitoring,
preferably with anticoagulation service or local facility equivalent,
prior to discharge from the hospital or clinic.

Total Knee
Duration: 7-10 days
Dalteparin 5,000 units/day $11.75
Enoxaparin 30mg every 12 hrs $16.92

Total Hip
Duration: 7-10 days
Dalteparin 5,000 units/day $11.75
Enoxaparin 40mg once/day $11.48
Enoxaparin 30mg every 12 hrs $16.92

b. Outpatient treatment or inpatient treatment to allow early
discharge of patients with uncomplicated Deep Venous

			Thrombosis or to allow early discharge of patients with Pulmonary Embolism. Duration: Until therapeutic on oral anticoagulants for 2 consecutive days. Dalteparin 200 units/kg/day $0.41/kg Enoxaparin Inpt 1.5mg/kg/day $0.44/kg Enoxaparin Inpt 1mg/kg/every 12 hrs $0.58/kg Enoxaparin Outpt 1mg/kg/every 12 hrs $0.58/kg c. Treatment of Trousseau's Syndrome or other cancers: Restricted to Oncology Service, for patients in whom warfarin is contraindicated or not effective. Duration: Not established. Dalteparin 5,000 units/day $11.75 Enoxaparin 40mg/day $11.48 c. Acute SCI injury (first 2-3 months after injury): Duration: Maximum = 12 weeks Dalteparin 5,000 units/day $11.75 Enoxaparin 40mg/day $11.48 e. Post-op prophylaxis of valve thrombosis or thromboembolism in mechanical heart valve patients [based on the Palo Alto VA Guidelines (Hospital Pharmacy 1/99 34:103-107).] Duration: Initiated 3-4 days before planned procedure, after discontinuation of warfarin and after INR has declined to < 2.5. LMWH should be discontinued at least 12 hours before the planned procedure. Post-procedure, warfarin is resumed the evening of or the day after the procedure. In patients undergoing a high-bleeding-risk procedure LMWH is not resumed.	

Dalteparin 100 units/kg twice daily $0.41/kg
Enoxaparin 1 mg/kg every 12 hrs $0.58/kg

f. Unstable angina and non-Q-wave myocardial infarction: Restricted
to Medicine Service or local facility equivalent.

Duration: At least 2 days and until clinically stable.
Enoxaparin: 1 mg/kg every 12 hrs $0.58/kg

g. February 2008: Criteria expanded to include the use of a LMWH for VTE prophylaxis in moderate to high risk abdominal or thoracic surgery patients for up to ten days.

Other Indications:

a. Availability for other indications will be processed through the
Non-Formulary process on a case-by-case basis.

VISN 20 Low Molecular Weight Heparin (LMWH) Dosing Recommendations
Sept 2004

Dalteparin:

Deep Vein Thrombosis and Pulmonary Embolus Prophylaxis

1. Hip or Knee Replacement Surgery

Dose: 2,500 Units subcutaneously (SC) 6-12 hours after surgery, then
5,000 Units SC once daily starting POD #1.
Duration: Anticoagulation should continue while in the hospital and a
minimum of 7-10 days postoperatively if discharged earlier. Patients at
high risk of VTE (previous VTE or malignancy) may benefit from extended
anticoagulation up to 3 weeks beyond the initial 7-10 days if they do not
have a high risk of bleeding. The decision to extend

			anticoagulation should be based on individual patient factors. If a decision is made not to continue anticoagulation beyond 7-10 days, aspirin for one month should be considered unless the patient has contraindications. Special populations: May consider increasing dose up to 30% in morbidly obese patients with high risk of VTE. Patients with serum creatinine up to 3.4mg/dl have been enrolled in clinical trials. 2. Outpatient or inpatient treatment to allow early discharge of uncomplicated DVT or PE. Dose: 200 Units/kg subcutaneously (SC) once daily. Duration: Until therapeutic on oral anticoagulants for 2 consecutive days. Oral anticoagulation can generally be started on the same day or the day after initiation of LMWH. In most studies, dalteparin was discontinued after 5-10 days. Special populations: Dose is based on total body weight. May consider dividing dose for markedly obese patients. Patients with serum creatinine up to 3.4mg/dl have been enrolled in clinical trials. 3. Treatment of Trousseau's syndrome, restricted to oncology service, with warfarin contraindication. Dose: 5,000 Units subcutaneously (SC) once daily. May consider 2,500 Units SC once daily in patients with no other risk factors for VTE or with greater risk of bleeding. Duration: Not established. Special populations: Very limited information on which to make recommendations. In general, may increase dose by up to 30% in morbidly obese patients and consider reduced dose in patients	

			with significant renal dysfunction. 4. Acute spinal cord injury (5,000 units/day to a maximum of 12 weeks). Dose: 5,000 Units subcutaneously once daily. Duration: Limited to a maximum of 12 weeks during the first 2-3 months following acute spinal cord injury. 5. Post-op prophylaxis of valve thrombosis or thromboembolism in mechanical heart valve patient. Dose: 100 Units/kg subcutaneously twice daily. Duration: Initiated 3-4 days before planned procedure, after discontinuation of warfarin and after INR has declined to < 2.5. Dalteparin should be discontinued at least 12 hours before the planned procedure. Post-procedure, warfarin is resumed the evening of or the day after the procedure. In patients undergoing a high-bleeding-risk procedure dalteparin is not resumed. In patients undergoing a non-high-bleeding-risk procedure, dalteparin is resumed at 100 Units/kg SC twice daily 24 hours after the procedure and continued until INR is 2.0. Special populations: Patients with serum creatinine > 2.0 mg/dl were not studied. Therapy, especially post-procedure resumption of anticoagulation, must be individualized to the patient's risk of bleeding. Enoxaparin 1. Unstable Angina and Non-Q-Wave Myocardial Infarction Dose: 1 mg/kg subcutaneously (SC) every 12 hours	

			Duration: At least 2 days and until clinically stable. Special populations: Dose is based on total body weight (TBW). Patients with creatinine clearance < 30 ml/min. were not included in trials. Date Added: Date(s) Discussed: January 29, 1999 February 21, 2003	
HS100	DANAZOL ORAL	DANOCRINE	Open Formulary - no restrictions	FORMULARY
MS200	DANTROLENE INJ 20MG	DANTRIUM	Restrictions per local facility	FORMULARY
MS200	DANTROLENE NA 100MG CAP	DANTRIUM	Restricted to Neurology Service or local equivalent	FORMULARY
MS200	DANTROLENE NA 25MG CAP	DANTRIUM	Restricted to Neurology Service or local equivalent	FORMULARY
AM900	DAPSONE 100MG TAB	AVLOSULFON	Open Formulary - no restrictions	FORMULARY
AM900	DAPSONE 25MG TAB	AVLOSULFON	Open Formulary - no restrictions	FORMULARY
AM900	DAPTOMYCIN		FORMULARY, RESTRICTED TO ID	FORMULARY
AM900	DAPTOMYCIN INJECTION	CUBICIN	Recommendation of Use for Daptomycin (Cubicin) JUNE 2009 Pharmacy Benefits Management Services, Medical Advisory Panel and VISN Pharmacist Executives The following recommendations are based on current medical evidence. The content of the document is dynamic and will be revised as new clinical data become available. The purpose of this document is to assist practitioners in clinical decision making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. The clinician, however, must make the ultimate judgment regarding the propriety of any course of treatment in light on individual patient situations Refer to the Recommendations of Use of Newer Gram-Positive Agents at http://vaww.pbm.va.gov. These recommendations are intended to cover the most common reasons for the use of daptomycin. They are not intended to cover all possible reasons for the use of daptomycin in clinical practice. FDA APPROVED INDICATION(S) FOR USE - Staphylococcus aureus bacteremia including patients with right-sided endocarditis - Complicated skin and skin structure infections caused by susceptible Gram-positive organisms (i.e., S. aureus, Streptococcus pyogenes, S.	FORMULARY

			agalactiae, S. dysgalactiae subsp. equismilis, Enterococcus faecalis) EXCLUSION CRITERIA (If one is selected, patient is NOT eligible) O Clinical evaluation of patient with positive microbiology culture (s) is consistent with colonization (not active infection). O Known resistance to daptomycin. O Treatment of pneumonia. Contraindications: O Known hypersensitivity to daptomycin. INCLUSION CRITERIA MRSA Infection (Select one indication and clinical scenario) O Documented MRSA bacteremia and/or right-sided endocarditis. O Documented complicated skin and skin structure infection caused by MRSA. O Other documented, serious MRSA infections. AND one of the following clinical scenarios: O Infection is unresponsive to vancomycin despite therapeutic vancomycin concentrations*. O In vitro non-susceptibility to vancomycin (including heteroresistant VISA strains); susceptibility to daptomycin should be documented*. O Patient does not tolerate vancomycin (i.e., allergy or serious adverse drug reaction) and treatment with an oral agent (e.g., TMP/SMX, minocycline, doxycycline or clindamycin) is not appropriate. Enterococcal Infection (Select one to be eligible) O Documented vancomycin and ampicillin resistant Enterococcus infection involving bloodstream or complicated skin and skin structure. O Other documented, serious Enterococcal infection in a patient who does not tolerate ampicillin and vancomycin. DOSAGE AND ADMINISTRATION (Refer to PI for dosage recommendations in organ dysfunction) Bacteremia/right-sided endocarditis: 6mg/kg intravenous infusion every 24 hours Complicated skin and skin structure infection: 4mg/kg intravenous infusion every 24 hours RECOMMENDED MONITORING The manufacturer recommends that patients be monitored for muscle pain or weakness, particularly of the distal extremities and to obtain weekly CPK levels while on therapy. More frequent monitoring of CPK should occur in patients with renal insufficiency or receiving (or recent discontinuation) of HMG-CoA reductase inhibitors. ISSUES FOR CONSIDERATION The manufacturer recommends that HMG-CoA reductase inhibitors be temporarily discontinued while receiving daptomycin. * VISA isolates often demonstrate decreased susceptibility to daptomycin June 2010 VISN 20 P&T .	
BL400	DARBEPOETIN INJ	ARANESP	VISN 20 Epoetin Alfa (Procrit) & Darbepoetin alfa	FORMULARY

			(Aranesp) Use Guidelines Epoetin and darbepoetin are not indicated for patients with cancer who are not receiving chemotherapy or radiation therapy. A. Rule out other causes of anemia 1. Adequate iron stores (ferritin >/= 100 ng/ml or transferrin saturation >/= 20%) 2. Adequate B12 and folate 3. Thyroid disease (normal TSH) 4. Occult GI bleeding (stool guaiac x 3) a. If iron deficient, replace iron to achieve a ferritin >/= 100 ng/ml or transferrin saturation >/= 20%. Recheck ferritin or transferrin saturation after 4 weeks of iron therapy. b. Consider IV iron if patient is taking a proton pump inhibitor and oral iron does not improve ferritin or is not tolerated. B. Indications 1. Anemia (Hgb /= 2.0 mg/dl or GFR < 50) 2. Zidovudine-treated HIV patients with documented endogenous erythropoietin levels of < 500 units/ml and receiving doses of zidovudine < 10 g/dl; HCT < 30%) associated with chemotherapy a. Epoetin and darbepoetin are indicated the treatment of anemia due to the effect of concomitantly administered myelosuppressive chemotherapy. b. Epoetin and darbepoetin are not indicated for use in patients receiving hormonal agents, therapeutic biologic products, or radiotherapy unless receiving concomitant myelosuppressive chemotherapy. c. Epoetin and darbepoetin are not indicated for patients receiving myelosuppressive therapy when the anticipated outcome is cure. d. Epoetin and darbepoetin use have not been demonstrated in controlled clinical trials to improve symptoms of anemia, quality of life, fatigue, or patient well-being e. Epoetin and darbepoetin should be discontinued following the completion of a chemotherapy course. f. Use the lowest dose needed to avoid red blood cell transfusion. 4. Symptomatic anemia (Hgb < 11 g/dl; HCT < 33%) associated with one of the following: a. Hematologic disorders (i.e. myelodysplasia) b. Unexplained anemia and endogenous erythropoietin level < 150 (anemia of chronic disease) c. Patients with hepatitis C undergoing therapy with interferon/peginterferon + ribavirin. C. Contraindications 1. Uncontrolled hypertension 2. Hypersensitivity to albumin (human), mammalian cell-derived products or polysorbate 80. 3. Use in patients with cancer not being treated with myelosuppressive chemotherapy. 4 Use in patients receiving hormonal agents, therapeutic biologic products, or radiotherapy unless receiving concomitant myelosuppressive chemotherapy. D. Warnings: 1. Renal failure: Patients experienced greater risks for death and serious	

			cardiovascular events when administered erythropoiesis-stimulating agents (ESAs) to target higher versus lower hemoglobin levels (13.5 vs. 11.3 g/dL; 14 vs. 10 g/dL) in two clinical studies. Dosing should be individualized to achieve and maintain hemoglobin levels within the range of 10 to 12 g/d 2. Cancer: a. ESAs shortened overall survival and/or increased the risk of tumor progression or recurrence in some clinical studies in patients with breast, non-small cell lung, head and neck, lymphoid, and cervical cancers. b. To decrease these risks, as well as the risk of serious cardio- and thrombovascular events, use the lowest dose needed to avoid red blood cell transfusion. c. Use ESAs only for treatment of anemia due to concomitant myelosuppressive chemotherapy. d. ESAs are not indicated for patients receiving myelosuppressive therapy when the anticipated outcome is cure. e. Discontinue following the completion of a chemotherapy course. 3. Perioperative Use: ESA's increased the rate of deep venous thromboses in patients not receiving prophylactic anticoagulation. Consider deep venous thrombosis prophylaxis in perioperative patients. E. Starting dosing schedule 1. Chronic kidney disease/HIV Epoetin alfa: 50-100 units/kg SQ every week (doses should be rounded to nearest 1,000 units/week); or Darbepoetin alfa: 0.75 mcg/kg SQ every other week (doses should be rounded to nearest 10 mcg); and Ferrous sulfate 325mg or ferrous gluconate 325mg PO once or twice a day 2. Anemia of chronic disease (ACD)//Hematologic disorders/ Radiation therapy Epoetin alfa: 50-100 units/kg SQ every week (doses should be rounded to nearest 1,000 units/week); or Darbepoetin alfa: 0.75 mcg/kg SQ every other week (doses should be rounded to nearest 10 mcg), and Ferrous sulfate 325mg or ferrous gluconate 325mg PO once or twice a day 3. Patients with Hepatitis C and Chemotherapy induced anemia Epoetin alfa: 40,000 units SQ every week, or Darbepoetin 200 mcg SQ q other week, or Darbepoetin 300 mcg SQ q three weeks, and Ferrous sulfate 325mg or ferrous gluconate 325mg PO once or twice a day F. Goals of Therapy 1. Hgb increases to 10-12g/dl, or 2. Hgb increases from baseline >/= 1.8 g/dl with improvement in quality of life, or 3. Decrease in transfusion requirements by the third month of treatment. G. Monitoring and discontinuing Therapy 1. Hgb should increase ~0.3g/dl per week, on average. 2. Monitor Hgb/Hct at baseline and every 3-4 weeks until

			patient reaches target Hgb/Hct then every 3 months. 3. Monitor ferritin at baseline, 1 month, 3 months, and then every 6 months. (For patients with chronic kidney disease also monitor transferrin saturation at same intervals.) 4. Monitor BP and P at each visit. 5. Administer Quality of Life measure at each visit. 6. Dose adjustments can be made after 4 weeks of therapy (sooner if there has been >/= 1.0 - 1.5g/dl increase in Hgb). a. Chronic Kidney Disease (1) If Hgb has not increased by 1-1.5g/dl from baseline in 3-4 weeks, increase dose by 25-50% and recheck in 4 weeks. (2) If there was a Hgb response of ~1-1.5g/dl at 3-4 weeks of therapy, maintain dose for another 4 weeks. (3) If the Hgb response is > 1.5g/dl at 3-4 weeks, reduce dose by 25-50% and recheck in 4 weeks. (4) If Hgb, quality of life, or transfusion goals have not been met at 8 weeks, increase the dose by 25 -50% and repeat this every 3-4 weeks until goal achieved or maximum dose of 60,000 units/week for epoetin alpha or 300 mcg every other week for darbepoetin alpha is reached. (5) If the Hgb is > 12g/dl but < 13 g/dl., the dose of epoetin/darbepoetin should be decreased by 25-50% and recheck in 4 weeks. (6) If the Hgb is = 13 g/dl, epoetin/darbepoetin should be held until the Hgb is = 12 g/dl. b. ACD/Chemotherapy/Hematologic disorders/Hepatitis C (1) If Hgb has not increased by 1-1.5g/dl from baseline in 3-4 weeks, increase dose by 20,000 units and recheck in 4 weeks. (2) If there was a Hgb response of ~1-1.5g/dl at 3-4 weeks of therapy, maintain that dose for another 4 weeks (3) If the Hgb response is > 1.5g/dl at 3-4 weeks, reduce dose by 25-50% and recheck in 4 weeks. (4) If Hgb, quality of life, or transfusion goals have not been met at 8 weeks, increase the dose by 20,000 units weekly for epoetin alpha or 100 mcg every other week for darbepoetin alpha and repeat this every 3-4 weeks until goal achieved or maximum dose of 60,000 units/week for epoetin alpha or 300 mcg every other week for darbepoetin alpha is reached. (5) If the Hgb is > 12g/dl but < 13 g/dl., the dose of epoetin/darbepoetin should be decreased by 25-50% and recheck in 4 weeks. (6) If the Hgb is = 13 g/dl, epoetin/darbepoetin should be held until the Hgb is = 12 g/dl. 7. If patient does not respond to the maximum dose (60,000 units/week for epoetin alpha or 300 mcg every other week for darbepoetin alpha) after the fourth month of therapy and has adequate iron stores, epoetin or darbepoetin should be discontinued. 8. For chronic

			kidney disease, a trial of IV iron may be warranted if erythropoietic growth factor requirements are extremely high (>/= 300 units/kg every week for epoetin alpha or 1.5 mcg/kg every other week for darbepoetin alpha) or target Hgb is not achieved. 9. Most hemodialysis patients will require IV iron. VISN 20 P&T Committee June 2005, May 2007, April 2009 . VA National Criteria for Use: Recombinant Erythropoietin for Hepatitis C Treatment-Related Anemia Patient Selection a. Before considering the use of erythropoietic factors, patients must initially undergo evaluation for other causes of anemia (e.g., bleeding, nutritional deficiency, hereditary) and should be treated appropriately o Obtain CBC and the following as indicated: peripheral smear, reticulocyte count, B12, folate. o Assess for adequate iron stores. If evidence of iron deficiency is found (ferritin < 10 g/dL or are symptomatic and have Hgb < 11 g/dL.** AND d. Does not have uncontrolled hypertension, known hypersensitivity to mammalian cell-derived products or known hypersensitivity to albumin or polysorbate 80 (with darbepoetin alfa). *Although evidence to determine the best indications for erythropoietin is unavailable, use of erythropoietin may be considered prior to dose reduction in the following situations: a. Documented evidence of cirrhosis b. Post-liver transplantation c. HIV co-infection ** Patients with Hgb 80% of original dose) 3. Reduce need for transfusion and/or hospitalization 4. Increase energy, activity, overall quality of life 5. Enhance treatment adherence Dosing (Refer to algorithm) o Initiate epoetin alfa 40,000 units subcutaneously once weekly. Response should be assessed at least every 2 weeks until Hgb is stable. Darbepoetin alfa 200 mcg subcutaneously every other week is an available alternative to epoetin, though there are no published studies currently available for its use in the setting of antiviral treatment. In addition, the response to darbepoetin is slower than to epoetin. Epo responders: o If there is an increase in Hgb >1 g/dL in any 2-week period and the ribavirin dose is at target, decrease the erythropoietic growth factor dose by 25%-50%. Alternatively, in patients who are below their target ribavirin dose, ribavirin dose may be increased without changing the erythropoietic dosing. Monitor Hgb accordingly. o If there is an increase in Hgb >1 g/dL from baseline after 3-4 weeks and ribavirin dose remains at target, maintain erythropoietic growth factor dose. Alternatively, in patients who are below their	

			target ribavirin dose, ribavirin dose may be increased without changing the erythropoietic dosing. Monitor Hgb accordingly. o If Hgb >12 g/dL and target ribavirin dose is achieved, hold epoetin/darbepoetin alfa dose and reinitiate with a 25% dose reduction if Hgb	

AM800	DARUNAVIR ORAL TAB	PREZISTA	PBM/MAP Criteria for Use: Darunavir/Ritonavir (PrezistaTM/ritonavir) FDA APPROVED INDICATION FOR USE Darunavir co-administered with 100mg ritonavir and other antiviral agents is indicated for the treatment of HIV infection in antiretroviral treatment-experienced adult patients, such as those with HIV-1 strains resistant to more than one protease inhibitor. EXCLUSION CRITERA (If one is selected, patient is NOT eligible) - HIV-2 - Patient with severe hepatic impairment (Child-Pugh Class C) INCLUSION CRITERIA (All must be selected for patient to be eligible) - Treatment-experienced patient (defined as 3 class experience including PI regimen) - Evidence of genotypic or phenotypic resistance to more than one PI - Evidence of virologic failure (documented by a viral load >1,000 copies/mL) - Able to construct a multi-drug regimen that includes, preferably, at least one additional active antiretroviral drug (if available) in addition to darunavir/ritonavir - Under the care of an experienced HIV practitioner DOSAGE AND ADMINISTRATION (Refer to PI for dosage recommendations in organ dysfunction) - Darunavir 600mg and ritonavir 100mg orally twice daily. This combination should be taken with food. RECOMMENDED MONITORING Inaddition to standard monitoring in a patient receiving antiretrovirals, the following is recommended: 1) Baseline and periodic monitoring of LFTs, particularly in patients with pre-existing liver dysfunction or co-infected with viral hepatitis B or C. 2) Baseline and periodic monitoring for new onset diabetes, exacerbation of pre-existing diabetes mellitus and hyperglycemia. - Monitor for skin rash including severe cases (erythema multiforme and Stevens-Johnson Syndrome) - Caution should be used in patients with a known sulfonamide allergy ISSUES FOR CONSIDERATION - Careful evaluation for potential drug-drug interactions should be done prior to initiation of darunavir/ritonavir. Both darunavir and ritonavir are substrate and inhibitors of CYP3A4. - Genotypic and/or phenotypic testing should be performed and results, along with treatment history, used to guide the use of darunavir. The presence of three or more of the following mutations is associated with decreased darunavir efficacy: V11I, V32I, L33F, I47V, I50V, I54L/M, G73S, T74P, L76V, I84V, and L89V, as is >40-fold change in sensitivity. June 2008 VISN 20 P&T Committee	FORMULARY

AN200	DAUNORUBICIN INJ	CERUBIDINE	Restrictions per local facility	FORMULARY
AD300	DEFEROXAMINE MESYLATE INJ	DESFERAL	Open Formulary - no restrictions	FORMULARY
AM800	DELAVIRDINE ORAL	RESCRIPTOR	Restricted to HIV prescribers	FORMULARY
AM250	DEMECLOCYCLINE HCL ORAL	DECLOMYCIN	Open Formulary - no restrictions	FORMULARY
CN203	DESFLURANE INHALATION	SUPRANE	Restrictions per local facility	FORMULARY
CN601	DESIPRAMINE HCL ORALTAB	NORPRAMIN	Open Formulary - no restrictions	FORMULARY
HS702	DESMOPRESSIN ACETATE INJ	DDAVP	Open Formulary - no restrictions	FORMULARY
HS702	DESMOPRESSIN INTRANASAL PUMP	DDAVP	Open Formulary - no restrictions	FORMULARY
HS200	DESOGESTREL 0.15/ETHINYL ESTRADIOL 30 TAB	RECLIPSEN	Open Formulary - no restrictions	FORMULARY
DE200	DESONIDE 0.05% TOPICAL CREAM	DESOWEN	Restricted to Dermatology or local equivalent	FORMULARY
HS051	DEXAMETHASONE 0.5MG, 0.75MG, 1.5MG TAB	DECADRON	Open Formulary - no restrictions	FORMULARY
HS051	DEXAMETHASONE 2MG, 4MG TAB	DECADRON	Open Formulary - no restrictions	FORMULARY
HS051	DEXAMETHASONE ELIXIR 0.5MG/5ML	DECADRON	Open Formulary - no restrictions	FORMULARY
HS051	DEXAMETHASONE INJ 4MG/ML 1ML	DECADRON	Open Formulary - no restrictions	FORMULARY
OP350	DEXAMETHASONE NA PHOS/NEOMYCIN/ OPH SOLN	NEODECADRON	Open Formulary - no restrictions	FORMULARY
OP300	DEXAMETHASONE NA PHOSPHATE OPH SOLN	MAXIDEX	Open Formulary - no restrictions	FORMULARY
OP300	DEXAMETHASONE OPHTH OINT 0.05%	MAXIDEX	Open Formulary - no restrictions	FORMULARY
OP350	DEXAMETHASONE/NEO/POLYMX OPH OINT	MAXITROL	Open Formulary - no restrictions	FORMULARY
OP350	DEXAMETHASONE/TOBRAMYCIN OPH OINT	TOBRADEX	Open Formulary - no restrictions	FORMULARY
OP350	DEXAMETHASONE/TOBRAMYCIN OPH SUSP	TOBRADEX	Open Formulary - no restrictions	FORMULARY
CN309	DEXMEDETOMIDINE INJ	PRECEDEX		FORMULARY
AN700	DEXRAZOXANE INJ	ZINECARD	Dexrazoxane (Zinecard) is non-formulary, restricted to Oncology Service, Marrow Transplant Service, or local facility equivalent for patients who have received doxorubicin to a cumulative dose of 300mg/m2 and would benefit from continued anthracycline chemotherapy, or patients who would benefit from doxorubicin and are at a greater than average risk for developing cardiotoxicity from such treatment (i.e., have compromised cardiac function or functional cardiac abnormalities).	FORMULARY
BL800	DEXTRAN 40 INJ	GENTRAN	Open Formulary - no restrictions	FORMULARY

BL800	DEXTRAN 70 INJ	N/A	Open Formulary - no restrictions	FORMULARY
BL800	DEXTRAN 75 INJ	N/A	Open Formulary - no restrictions	FORMULARY
BL800	DEXTRAN HM (DEXTRAN 70/DEXTROSE 10% WATER)	N/A	Open Formulary - no restrictions	FORMULARY
AD900	DEXTRAN-1 INJ 150MG/ML 20ML	PROMIT	Open Formulary - no restrictions	FORMULARY
CN801	DEXTROAMPHETAMINE REGULAR RELEASE ORAL CAP & TAB	DEXEDRINE	Dextroamphetamine regular release is formulary, restricted to Neurology, Geriatrics, Psychiatry/Mental Health, Pulmonary/Sleep Medicine Specialists, or local facility equivalent.) Dextroamphetamine sustained release is restricted as a second-line for patients who have contraindications to or do not respond to regular release dextroamphetamine. Sept 1999, August 2007 VISN 20 P&T	FORMULARY
CN801	DEXTROAMPHETAMINE SA CAP	N/A	Dextroamphetamine regular release is formulary, restricted to Neurology, Geriatrics, Psychiatry/Mental Health, Pulmonary/Sleep Medicine Specialists, or local facility equivalent.) Dextroamphetamine sustained release is restricted as a second-line for patients who have contraindications to or do not respond to regular release dextroamphetamine. Sept 1999, August 2007 VISN 20 P&T	FORMULARY
RE302	DEXTROMETHORPHAN/GUAIFENESIN (SF) LIQUID (OTC)	ROBITUSSIN DM	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.2% NACL INJ 100	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.2% NACL/20MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.2% NACL/30MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.2% NACL/40MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.33% NACL/20MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.45% NACL INJ 500ML	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.45% NACL INJ 1000ML	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.45% NACL/20MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.45% NACL/30MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.45% NACL/40MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.9% NACL INJ 100ML	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/0.9% NACL/20MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/LACTATED RINGERS	N/A	Open Formulary - no restrictions	FORMULARY

TN102	DEXTROSE 5%/WATER/20MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 5%/WATER/40MEQ KCL	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE 10%/0.45% NACL INJ 1000ML	N/A	Open Formulary - no restrictions	FORMULARY
PH000	DEXTROSE 25%INJ	N/A	Open Formulary - no restrictions	FORMULARY
HS503	DEXTROSE 50%/WATER INJ 50ML	N/A	Open Formulary - no restrictions	FORMULARY
TN101	DEXTROSE INJ (5,10,20, 50, 70%)	N/A	Open Formulary - no restrictions	FORMULARY
HS503	DEXTROSE SQUEEZE TUBE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
TN102	DEXTROSE/ISOLYTE INJ	N/A	Open Formulary - no restrictions	FORMULARY
IR200	DEXTROSE/PERITONEAL DIALYSIS SOLN	N/A	Open Formulary - no restrictions	FORMULARY
XA305	DIAPER W/ELASTIC STRAPS	N/A	Open Formulary - no restrictions	FORMULARY
XA900	DIAPHRAGM KIT (OTC) 65MM,70MM,75MM,80MM	N/A	Open Formulary - no restrictions	FORMULARY
DX900	DIASTIX (GLUCOSE) TEST STRIP (OTC)	DIASTIX	Open Formulary - no restrictions	FORMULARY
CN302	DIAZEPAM 5MG TAB	VALIUM	Open Formulary - no restrictions	FORMULARY
CN302	DIAZEPAM 5MG/ML INJ 2ML	VALIUM	Open Formulary - no restrictions	FORMULARY
DE700	DIBUCAINE 1% OINT (OTC)	NUPERCAINAL	Open Formulary - no restrictions	FORMULARY
OP300	DICLOFENAC NA OPH SOLN	VOLTAREN	Open Formulary - no restrictions	FORMULARY
MS102	DICLOFENAC ORAL TAB, EC	VOLTAREN	Open Formulary - no restrictions	FORMULARY
AM053	DICLOXACILLIN NA 250MG CAP	DYNAPEN	Open Formulary - no restrictions	FORMULARY
AU350	DICYCLOMINE HCL 10MG, 20MG CAP, TAB	BENTYL	Open Formulary - no restrictions	FORMULARY
AU350	DICYCLOMINE HCL INJ	BENTYL	Open Formulary - no restrictions	FORMULARY
AU350	DICYCLOMINE HCL SYRUP	BENTYL	Restricted to patients unable to take oral tablets.	FORMULARY
AM800	DIDANOSINE ORAL - RR and EC	VIDEX	Restricted to ID Service or local equivalent	FORMULARY
CV050	DIGOXIN (LANOXIN) 0.125MG, 0.25MG TAB	LANOXIN	Open Formulary - no restrictions	FORMULARY
CV050	DIGOXIN ELIXIR 0.05MG/ML 60ML	LANOXIN	Open Formulary - no restrictions	FORMULARY
AD900	DIGOXIN IMMUNE FAB (OVINE) INJ	DIGIBIND	Open Formulary - no restrictions	FORMULARY
CV050	DIGOXIN INJ 0.5MG/2ML	LANOXIN	Open Formulary - no restrictions	FORMULARY
CN105	DIHYDROERGOTAMINE MESYLATE INJ	DHE	Open Formulary - no restrictions	FORMULARY
VT503	DIHYDROTACHYSTEROL ORAL	DHT	Open Formulary - no restrictions	FORMULARY
CV200	DILTIAZEM (TIAZAC) 120, 180, 240, 300MG SA CAP	TIAZAC	Open Formulary - no restrictions	FORMULARY

CV200	DILTIAZEM HCL INJ	CARDIZEM	Open Formulary - no restrictions	FORMULARY
CV200	DILTIAZEM HCL IR ORAL TAB	CARDIZEM	Diltiazem IR is formulary, restricted to inpatient use. Diltiazem IR is available for outpatient use on a non-formulary basis only for patients requiring tube feeding administration, or with inability to swallow, headache unresponsive to other therapies, or esophageal spasms. July 2004	FORMULARY
AD300	DIMERCAPROL INJ	BAL IN OIL	Open Formulary - no restrictions	FORMULARY
GU900	DIMETHYLSULFOXIDE URH SOLN	DMSO	Open Formulary - no restrictions	FORMULARY
AH200	DIPHENHYDRAMINE HCL 25MG, 50MG CAP	BENADRYL	Open Formulary - no restrictions	FORMULARY
AH200	DIPHENHYDRAMINE INJ 50MG/ML	BENADRYL	Open Formulary - no restrictions	FORMULARY
AH200	DIPHENHYDRAMINE SYRUP 2.5MG/ML	BENADRYL	Open Formulary - no restrictions	FORMULARY
GA400	DIPHENOXYLATE/ATROPINE LIQUID	LOMOTIL	Open Formulary - no restrictions	FORMULARY
GA400	DIPHENOXYLATE/ATROPINE TAB	LOMOTIL	Open Formulary - no restrictions	FORMULARY
IM200	DIPHTHERIA/TETANUS TOXOID INJ	N/A	Open Formulary - no restrictions	FORMULARY
OP103	DIPIVEFRIN HCL 0.1% OPH SOLN	PROPINE	Open Formulary - no restrictions	FORMULARY
BL700	DIPYRIDAMOLE 25MG ORAL	PERSANTINE	Open Formulary - no restrictions	FORMULARY
DX900	DIPYRIDAMOLE INJ	PERSANTINE	Open Formulary - no restrictions	FORMULARY
XA305	DISPOSABLE DIAPER	N/A	Open Formulary - no restrictions	FORMULARY
XA301	DISPOSABLE UNDERPAD	N/A	Restricted to one case per month	FORMULARY
AD100	DISULFIRAM (ANTABUSE) 250MG TAB	ANTABUSE	Open Formulary - no restrictions	FORMULARY
AD100	DISULFIRAM (ANTABUSE) 500MG TAB	ANTABUSE	Open Formulary - no restrictions	FORMULARY
CN101	DIVALPROEX 24 HR (ER) SA TAB	DEPAKOTE ER (EXTENDED RELEASE)	Divalproex sodium SA (Depakote ER) is the only available divalproex sodium product on the VISN 20 Formulary. March 2006 VISN 20 P&T Committee	FORMULARY
RE302	DM 10/GUAIFENESN 100MG/5ML (ALCOHOL FREE) (OTC)	ROBITUSSIN DM	Open Formulary - no restrictions	FORMULARY
AU100	DOBUTAMINE INJ 250MG	DOBUTREX	Open Formulary - no restrictions	FORMULARY
AN900	DOCETAXEL INJ	TAXOTERE	Restricted to Hematology/Oncology or local facility equivalent.	FORMULARY
RS300	DOCUSATE (OTC) ENEMA, RECTAL	ENEMEEZ	Open Formulary - no restrictions	FORMULARY
GA205	DOCUSATE LIQUID 60MG/15ML 473M	COLACE	Open Formulary - no restrictions	FORMULARY
GA205	DOCUSATE SODIUM 250MG CAP	DOS	Open Formulary - no restrictions	FORMULARY

GA204	DOCUSATE/SENNOSIDES ORAL TAB	N/A	Open Formulary - no restrictions	FORMULARY
CN900	DONEPEZIL ORAL	ARICEPT		FORMULARY
AU100	DOPAMINE INJ 400MG/5ML INJ	INTROPIN	Open Formulary - no restrictions	FORMULARY
AU100	DOPAMINE INJ 800MG/D5W 500ML PRE-MIXDEXTROSE 5%/L	INTROPIN	Open Formulary - no restrictions	FORMULARY
OP109	DORZOLAMIDE HCL OPH SOLN	TRUSOPT	Dorzolamide (Trusopt) is formulary, restricted to Ophthalmology/Eye Clinic or local facility equivalent as second line therapy. Brinzolamide (Azopt) is non-formulary, restricted to Ophthalmology/Eye Clinic or local facility equivalent. August 2007	FORMULARY
OP105	DORZOLAMIDE/TIMOLOL OPHTH SOLN	COSOPT	Dorzolamide/timolol (Cosopt) ophthalmic solution is restricted to Ophthalmology/Eye Clinic or local facility equivalent. January 2001 VISN 20 P&T Committee	FORMULARY
RE900	DOXAPRAM HCL INJ	DOPRAM	Restrictions per local facility	FORMULARY
CV150	DOXAZOSIN ORAL	CARDURA	Open Formulary - no restrictions	FORMULARY
CN601	DOXEPIN HCL 10MG, 25MG, 50MG CAP	SINEQUAN	Open Formulary - no restrictions	FORMULARY
CN601	DOXEPIN ORAL LIQUID	N/A	Open Formulary - no restrictions	FORMULARY
AN200	DOXORUBICIN INJ	ADRIAMYCIN	Restrictions per local facility	FORMULARY
AM250	DOXYCYCLINE CAP/TAB	VIBRAMYCIN	Open Formulary - no restrictions	FORMULARY
AM250	DOXYCYCLINE INJ 100MG	VIBRAMYCIN	Restrictions per local facility	FORMULARY
XA199	DRESSING ALGINATE	N/A	Open Formulary - no restrictions	FORMULARY
XA199	DRESSING HYDROCOLLOID	N/A	Open Formulary - no restrictions	FORMULARY
XA199	DRESSING HYDROGEL	N/A	Open Formulary - no restrictions	FORMULARY
XA103	DRESSING NON-ADHESIVE OIL/EMULSION	N/A	Open Formulary - no restrictions	FORMULARY
XA900	DRESSING TRAY FOR CENTRAL LINE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA199	DRESSING TRAYS	N/A	Open Formulary - no restrictions	FORMULARY
XA103	DRESSING, ALLEVYN (OTC)	ALLEVYN	Open Formulary - no restrictions	FORMULARY
XA199	DRESSING, PROFORE 4-LAYER	PROFORE DRESSING	Open Formulary - no restrictions	FORMULARY
XA199	DRESSING,CLEARSITE (OTC)	CLEARSITE	Open Formulary - no restrictions	FORMULARY
XA199	DRESSING,DUODERM (OTC)	DUODERM	Open Formulary - no restrictions	FORMULARY
XA199	DRESSING,PROFORE-LF 4-LAYER SN#66020626	N/A	Open Formulary - no restrictions	FORMULARY
XA199	DRESSING,RESTORE (OTC)	RESTORE	Open Formulary - no restrictions	FORMULARY

XA199	DRESSING,SORBSAN (OTC)	SORSBAN	Open Formulary - no restrictions	FORMULARY
XA599	DRIP COLLECTOR CONVEEN #5410 (OTC)	CONVEEN	Open Formulary - no restrictions	FORMULARY
CN205	DROPERIDOL INJ 2.5MG/ML 2ML	INAPSINE	Restrictions per local facility	FORMULARY
XA604	DUODERM HYDROGEL (OTC)	DUODERM	Open Formulary - no restrictions	FORMULARY
OP102	ECHOTHIOPHATE IODIDE 0.125% OP	PHOSPHOLINE IODIDE	Open Formulary - no restrictions	FORMULARY
OP102	ECHOTHIOPHATE IODIDE 0.25% OP	PHOSPHOLINE IODIDE	Open Formulary - no restrictions	FORMULARY
AD300	EDETATE CALCIUM DISODIUM INJ	CALCIUM DISODIUM VERSENATE	Open Formulary - no restrictions	FORMULARY
AU300	EDROPHONIUM INJ 10MG/ML 15ML	TENSILON	Restrictions per local facility	FORMULARY
AM800	EFAVIRENZ 200MG CAP	SUSTIVA	Restricted to HIV prescribers	FORMULARY
AM800	EFAVIRENZ/EMTRICITABINE/TENOFOVIR TAB	ATRIPLA	Restricted to HIV prescribers	FORMULARY
XA108	ELASTOPLAST (OTC)	ELASTOPLAST	Open Formulary - no restrictions	FORMULARY
XA900	EMPTY FLEXIBLE CONTAINER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
AM800	EMTRICITABINE ORAL	EMTRIVA	Restricted to HIV prescribers and Infectious Disease Service or local equivalent(s).	FORMULARY
AM800	EMTRICITABINE/TENOFOVIR ORAL	TRUVADA	Restricted to HIV prescribers and Infectious Disease Service or local equivalent(s).	FORMULARY
CV800	ENALAPRIL ORAL TAB	VASOTEC	Open Formulary - no restrictions	FORMULARY
CV800	ENALAPRILAT INJ	VASOTEC	Restrictions per local facility	FORMULARY
XA900	ENEMA BAG (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CN201	ENFLURANE INHALATION	ETHRANE	Open Formulary - no restrictions	FORMULARY
AM800	ENFUVIRTIDE INJ	FUZEON	Restricted to HIV prescribers	FORMULARY
BL100	ENOXAPARIN INJ	LOVENOX	VISN 20 Low Molecular Weight Heparin (LMWH) Criteria - November 2004 Dalteparin is available for patients allergic to enoxaparin. Enoxaparin is available for patients allergic to dalteparin. 1. When enoxaparin and dalteparin are dosed once a day, the cost of these agents is similar and either agent can be used. 2. Dalteparin is the preferred agent for situations in which enoxaparin would be dosed more than once a day, except for patients with unstable angina and non-Q-wave myocardial infarction or who are allergic to dalteparin. Each indication below lists the agents, recommended dosage regimens, and costs as of Nov 2004: Approved Indications: a. DVT/PE prophylaxis for perioperative patients undergoing hip and knee replacement/surgery. Appropriate follow-up and	FORMULARY

			monitoring, preferably with anticoagulation service or local facility equivalent, prior to discharge from the hospital or clinic. Total Knee Duration: 7-10 days Dalteparin 5,000 units/day $11.75 Enoxaparin 30mg every 12 hrs $16.92 Total Hip Duration: 7-10 days Dalteparin 5,000 units/day $11.75 Enoxaparin 40mg once/day $11.48 Enoxaparin 30mg every 12 hrs $16.92 b. Outpatient treatment or inpatient treatment to allow early discharge of patients with uncomplicated Deep Venous Thrombosis or to allow early discharge of patients with Pulmonary Embolism. Duration: Until therapeutic on oral anticoagulants for 2 consecutive days. Dalteparin 200 units/kg/day $0.41/kg Enoxaparin Inpt 1.5mg/kg/day $0.44/kg Enoxaparin Inpt 1mg/kg/every 12 hrs $0.58/kg Enoxaparin Outpt 1mg/kg/every 12 hrs $0.58/kg c. Treatment of Trousseau's Syndrome or other cancers: Restricted to Oncology Service, for patients in whom warfarin is contraindicated or not effective. Duration: Not established. Dalteparin 5,000 units/day $11.75 Enoxaparin 40mg/day $11.48 c. Acute SCI injury (first 2 -3 months after injury): Duration: Maximum = 12 weeks Dalteparin 5,000 units/day $11.75 Enoxaparin 40mg/day $11.48 e. Post-op prophylaxis of valve thrombosis or thromboembolism in mechanical heart valve patients [based on the Palo Alto VA Guidelines (Hospital Pharmacy 1/99 34:103-107).] Duration: Initiated 3-4 days before planned procedure, after discontinuation of warfarin and after INR has declined to < 2.5. LMWH should be discontinued at least 12 hours before the planned procedure. Post-procedure, warfarin is resumed the evening of or the day after the procedure. In patients undergoing a high-bleeding-risk procedure LMWH is not resumed. Dalteparin 100 units/kg twice daily $0.41/kg Enoxaparin 1 mg/kg every 12 hrs $0.58/kg f. Unstable angina and non-Q-wave myocardial infarction: Restricted to Medicine Service or local facility equivalent. Duration: At least 2 days and until clinically stable. Enoxaparin: 1 mg/kg every 12 hrs $0.58/kg g. February 2008: Criteria expanded to include the use of a LMWH for VTE prophylaxis in moderate to high risk abdominal or thoracic surgery patients for up to ten days. Other Indications: a. Availability for other indications will be processed through the Non-Formulary process on a case-by-case basis. VISN 20 Low Molecular Weight Heparin (LMWH) Dosing Recommendations Sept 2004 Dalteparin: Deep Vein Thrombosis and Pulmonary Embolus Prophylaxis	

			1. Hip or Knee Replacement Surgery Dose: 2,500 Units subcutaneously (SC) 6-12 hours after surgery, then 5,000 Units SC once daily starting POD #1. Duration: Anticoagulation should continue while in the hospital and a minimum of 7-10 days postoperatively if discharged earlier. Patients at high risk of VTE (previous VTE or malignancy) may benefit from extended anticoagulation up to 3 weeks beyond the initial 7-10 days if they do not have a high risk of bleeding. The decision to extend anticoagulation should be based on individual patient factors. If a decision is made not to continue anticoagulation beyond 7-10 days, aspirin for one month should be considered unless the patient has contraindications. Special populations: May consider increasing dose up to 30% in morbidly obese patients with high risk of VTE. Patients with serum creatinine up to 3.4mg/dl have been enrolled in clinical trials. 2. Outpatient or inpatient treatment to allow early discharge of uncomplicated DVT or PE. Dose: 200 Units/kg subcutaneously (SC) once daily. Duration: Until therapeutic on oral anticoagulants for 2 consecutive days. Oral anticoagulation can generally be started on the same day or the day after initiation of LMWH. In most studies, dalteparin was discontinued after 5-10 days. Special populations: Dose is based on total body weight. May consider dividing dose for markedly obese patients. Patients with serum creatinine up to 3.4mg/dl have been enrolled in clinical trials. 3. Treatment of Trousseau's syndrome, restricted to oncology service, with warfarin contraindication. Dose: 5,000 Units subcutaneously (SC) once daily. May consider 2,500 Units SC once daily in patients with no other risk factors for VTE or with greater risk of bleeding. Duration: Not established. Special populations: Very limited information on which to make recommendations. In general, may increase dose by up to 30% in morbidly obese patients and consider reduced dose in patients with significant renal dysfunction. 4. Acute spinal cord injury (5,000 units/day to a maximum of 12 weeks). Dose: 5,000 Units subcutaneously once daily. Duration: Limited to a maximum of 12 weeks during the first 2-3 months following acute spinal cord injury. 5. Post-op prophylaxis of valve thrombosis or thromboembolism in mechanical heart valve patient. Dose: 100 Units/kg subcutaneously twice daily. Duration: Initiated 3-4 days before planned procedure, after discontinuation of warfarin and after INR has declined to < 2.5. Dalteparin	

			should be discontinued at least 12 hours before the planned procedure. Post-procedure, warfarin is resumed the evening of or the day after the procedure. In patients undergoing a high-bleeding-risk procedure dalteparin is not resumed. In patients undergoing a non-high-bleeding-risk procedure, dalteparin is resumed at 100 Units/kg SC twice daily 24 hours after the procedure and continued until INR is 2.0. Special populations: Patients with serum creatinine > 2.0 mg/dl were not studied. Therapy, especially post-procedure resumption of anticoagulation, must be individualized to the patient's risk of bleeding. Enoxaparin 1. Unstable Angina and Non-Q-Wave Myocardial Infarction Dose: 1 mg/kg subcutaneously (SC) every 12 hours Duration: At least 2 days and until clinically stable. Special populations: Dose is based on total body weight (TBW). Patients with creatinine clearance < 30 ml/min. were not included in trials.	
CN500	ENTACAPONE ORAL	COMTAN	Entacapone (Comtan) is formulary, restricted to VA Neurology Service use or approval, for patients who: (1) have been properly diagnosed by Neurology Service as having idiopathic Parkinson's disease; (2) have shown to clearly respond to levodopa/carbidopa on motor testing; (3) exhibit end-of-dose wearing off of motor response to levodopa/carbidopa at dosages of at least 600mg per day of levodopa; and (4) have been monitored closely by ongoing visits in Neurology Clinic	FORMULARY
AM800	ENTECAVIR ORAL TABLET AND ORAL SOLUTION	BARACLUDE	Entecavir is restricted to GI/Hepatology and ID, or local facility equivalent. January 2007	FORMULARY
AU100	EPHEDRINE INJ	EFEDRON	Open Formulary - no restrictions	FORMULARY
AU100	EPINEPHRINE 0.3MG/0.3ML INJ EPI-PEN	EPIPEN	Open Formulary - no restrictions	FORMULARY
AU100	EPINEPHRINE INJ 0.1MG/ML 1ML, 10ML	ADRENALIN	Open Formulary - no restrictions	FORMULARY
AU100	EPINEPHRINE INJ 1MG/ML 1ML TUBEX, 30ML INJ	ADRENALIN	Open Formulary - no restrictions	FORMULARY
BL400	EPOETIN ALFA,RECOMBINANT INJ	PROCRIT, EPOGEN	VISN 20 Epoetin Alfa (Procrit) & Darbepoetin alfa (Aranesp) Use Guidelines Epoetin and darbepoetin are not indicated for patients with cancer who are not receiving chemotherapy or radiation therapy. A. Rule out other causes of anemia 1. Adequate iron stores (ferritin >/= 100 ng/ml or transferrin saturation >/= 20%) 2. Adequate B12 and folate 3. Thyroid disease (normal TSH) 4. Occult GI bleeding (stool guaiac x 3) a. If iron deficient, replace iron to achieve a ferritin >/= 100 ng/ml or transferrin saturation >/= 20%. Recheck ferritin or transferrin saturation after 4 weeks of iron therapy. b.	FORMULARY

			Consider IV iron if patient is taking a proton pump inhibitor and oral iron does not improve ferritin or is not tolerated. B. Indications 1. Anemia (Hgb /= 2.0 mg/dl or GFR < 50) 2. Zidovudine-treated HIV patients with documented endogenous erythropoietin levels of < 500 units/ml and receiving doses of zidovudine < 10 g/dl; HCT < 30%) associated with chemotherapy a. Epoetin and darbepoetin are indicated the treatment of anemia due to the effect of concomitantly administered myelosuppressive chemotherapy. b. Epoetin and darbepoetin are not indicated for use in patients receiving hormonal agents, therapeutic biologic products, or radiotherapy unless receiving concomitant myelosuppressive chemotherapy. c. Epoetin and darbepoetin are not indicated for patients receiving myelosuppressive therapy when the anticipated outcome is cure. d. Epoetin and darbepoetin use have not been demonstrated in controlled clinical trials to improve symptoms of anemia, quality of life, fatigue, or patient well-being e. Epoetin and darbepoetin should be discontinued following the completion of a chemotherapy course. f. Use the lowest dose needed to avoid red blood cell transfusion. 4. Symptomatic anemia (Hgb < 11 g/dl; HCT < 33%) associated with one of the following: a. Hematologic disorders (i.e. myelodysplasia) b. Unexplained anemia and endogenous erythropoietin level < 150 (anemia of chronic disease) c. Patients with hepatitis C undergoing therapy with interferon/peginterferon + ribavirin. C. Contraindications 1. Uncontrolled hypertension 2. Hypersensitivity to albumin (human), mammalian cell-derived products or polysorbate 80. 3. Use in patients with cancer not being treated with myelosuppressive chemotherapy. 4 Use in patients receiving hormonal agents, therapeutic biologic products, or radiotherapy unless receiving concomitant myelosuppressive chemotherapy. D. Warnings: 1. Renal failure: Patients experienced greater risks for death and serious cardiovascular events when administered erythropoiesis-stimulating agents (ESAs) to target higher versus lower hemoglobin levels (13.5 vs. 11.3 g/dL; 14 vs. 10 g/dL) in two clinical studies. Dosing should be individualized to achieve and maintain hemoglobin levels within the range of 10 to 12 g/d 2. Cancer: a. ESAs shortened overall survival and/or increased the risk of tumor progression or recurrence in some clinical studies in patients with breast, non-small cell lung, head and neck, lymphoid, and cervical	

			cancers. b. To decrease these risks, as well as the risk of serious cardio- and thrombovascular events, use the lowest dose needed to avoid red blood cell transfusion. c. Use ESAs only for treatment of anemia due to concomitant myelosuppressive chemotherapy. d. ESAs are not indicated for patients receiving myelosuppressive therapy when the anticipated outcome is cure. e. Discontinue following the completion of a chemotherapy course. 3. Perioperative Use: ESA's increased the rate of deep venous thromboses in patients not receiving prophylactic anticoagulation. Consider deep venous thrombosis prophylaxis in perioperative patients. E. Starting dosing schedule 1. Chronic kidney disease/HIV Epoetin alfa: 50-100 units/kg SQ every week (doses should be rounded to nearest 1,000 units/week); or Darbepoetin alfa: 0.75 mcg/kg SQ every other week (doses should be rounded to nearest 10 mcg); and Ferrous sulfate 325mg or ferrous gluconate 325mg PO once or twice a day 2. Anemia of chronic disease (ACD)//Hematologic disorders/ Radiation therapy Epoetin alfa: 50-100 units/kg SQ every week (doses should be rounded to nearest 1,000 units/week); or Darbepoetin alfa: 0.75 mcg/kg SQ every other week (doses should be rounded to nearest 10 mcg), and Ferrous sulfate 325mg or ferrous gluconate 325mg PO once or twice a day 3. Patients with Hepatitis C and Chemotherapy induced anemia Epoetin alfa: 40,000 units SQ every week, or Darbepoetin 200 mcg SQ q other week, or Darbepoetin 300 mcg SQ q three weeks, and Ferrous sulfate 325mg or ferrous gluconate 325mg PO once or twice a day F. Goals of Therapy 1. Hgb increases to 10-12g/dl, or 2. Hgb increases from baseline >/= 1.8 g/dl with improvement in quality of life, or 3. Decrease in transfusion requirements by the third month of treatment. G. Monitoring and discontinuing Therapy 1. Hgb should increase ~0.3g/dl per week, on average. 2. Monitor Hgb/Hct at baseline and every 3-4 weeks until patient reaches target Hgb/Hct then every 3 months. 3. Monitor ferritin at baseline, 1 month, 3 months, and then every 6 months. (For patients with chronic kidney disease also monitor transferrin saturation at same intervals.) 4. Monitor BP and P at each visit. 5. Administer Quality of Life measure at each visit. 6. Dose adjustments can be made after 4 weeks of therapy (sooner if there has been >/= 1.0 - 1.5g/dl increase in Hgb). a. Chronic Kidney Disease (1) If Hgb has not increased by 1-1.5g/dl from baseline in 3-4	

			weeks, increase dose by 25-50% and recheck in 4 weeks. (2) If there was a Hgb response of ~1-1.5g/dl at 3-4 weeks of therapy, maintain dose for another 4 weeks. (3) If the Hgb response is > 1.5g/dl at 3-4 weeks, reduce dose by 25-50% and recheck in 4 weeks. (4) If Hgb, quality of life, or transfusion goals have not been met at 8 weeks, increase the dose by 25 -50% and repeat this every 3-4 weeks until goal achieved or maximum dose of 60,000 units/week for epoetin alpha or 300 mcg every other week for darbepoetin alpha is reached. (5) If the Hgb is > 12g/dl but < 13 g/dl., the dose of epoetin/darbepoetin should be decreased by 25-50% and recheck in 4 weeks. (6) If the Hgb is = 13 g/dl, epoetin/darbepoetin should be held until the Hgb is = 12 g/dl. b. ACD/Chemotherapy/Hematologic disorders/Hepatitis C (1) If Hgb has not increased by 1-1.5g/dl from baseline in 3-4 weeks, increase dose by 20,000 units and recheck in 4 weeks. (2) If there was a Hgb response of ~1-1.5g/dl at 3-4 weeks of therapy, maintain that dose for another 4 weeks (3) If the Hgb response is > 1.5g/dl at 3-4 weeks, reduce dose by 25-50% and recheck in 4 weeks. (4) If Hgb, quality of life, or transfusion goals have not been met at 8 weeks, increase the dose by 20,000 units weekly for epoetin alpha or 100 mcg every other week for darbepoetin alpha and repeat this every 3-4 weeks until goal achieved or maximum dose of 60,000 units/week for epoetin alpha or 300 mcg every other week for darbepoetin alpha is reached. (5) If the Hgb is > 12g/dl but < 13 g/dl., the dose of epoetin/darbepoetin should be decreased by 25-50% and recheck in 4 weeks. (6) If the Hgb is = 13 g/dl, epoetin/darbepoetin should be held until the Hgb is = 12 g/dl. 7. If patient does not respond to the maximum dose (60,000 units/week for epoetin alpha or 300 mcg every other week for darbepoetin alpha) after the fourth month of therapy and has adequate iron stores, epoetin or darbepoetin should be discontinued. 8. For chronic kidney disease, a trial of IV iron may be warranted if erythropoietic growth factor requirements are extremely high (>/= 300 units/kg every week for epoetin alpha or 1.5 mcg/kg every other week for darbepoetin alpha) or target Hgb is not achieved. 9. Most hemodialysis patients will require IV iron. VISN 20 P&T Committee June 2005, May 2007, April 2009 . VA National Criteria for Use: Recombinant Erythropoietin for Hepatitis C Treatment-Related Anemia Patient Selection a. Before considering the use of erythropoietic factors, patients	

			must initially undergo evaluation for other causes of anemia (e.g., bleeding, nutritional deficiency, hereditary) and should be treated appropriately o Obtain CBC and the following as indicated: peripheral smear, reticulocyte count, B12, folate. o Assess for adequate iron stores. If evidence of iron deficiency is found (ferritin < 10 g/dL or are symptomatic and have Hgb < 11 g/dL.** AND d. Does not have uncontrolled hypertension, known hypersensitivity to mammalian cell-derived products or known hypersensitivity to albumin or polysorbate 80 (with darbepoetin alfa). *Although evidence to determine the best indications for erythropoietin is unavailable, use of erythropoietin may be considered prior to dose reduction in the following situations: a. Documented evidence of cirrhosis b. Post-liver transplantation c. HIV co-infection ** Patients with Hgb 80% of original dose) 3. Reduce need for transfusion and/or hospitalization 4. Increase energy, activity, overall quality of life 5. Enhance treatment adherence Dosing (Refer to algorithm) o Initiate epoetin alfa 40,000 units subcutaneously once weekly. Response should be assessed at least every 2 weeks until Hgb is stable. Darbepoetin alfa 200 mcg subcutaneously every other week is an available alternative to epoetin, though there are no published studies currently available for its use in the setting of antiviral treatment. In addition, the response to darbepoetin is slower than to epoetin. Epo responders: o If there is an increase in Hgb >1 g/dL in any 2-week period and the ribavirin dose is at target, decrease the erythropoietic growth factor dose by 25%-50%. Alternatively, in patients who are below their target ribavirin dose, ribavirin dose may be increased without changing the erythropoietic dosing. Monitor Hgb accordingly. o If there is an increase in Hgb >1 g/dL from baseline after 3-4 weeks and ribavirin dose remains at target, maintain erythropoietic growth factor dose. Alternatively, in patients who are below their target ribavirin dose, ribavirin dose may be increased without changing the erythropoietic dosing. Monitor Hgb accordingly. o If Hgb >12 g/dL and target ribavirin dose is achieved, hold epoetin/darbepoetin alfa dose and reinitiate with a 25% dose reduction if Hgb	
BL100	EPTIFIBATIDE INJ	INTEGRELIN	Restricted to Cardiology Service or local equivalent	FORMULARY
CN900	ERGOLOID MESYLATES ORAL RR TAB	HYDERGINE	Open Formulary - no restrictions	FORMULARY

GU600	ERGONOVINE MALEATE INJ	ERGOTRATE	Restrictions per local facility	FORMULARY
AM119	ERTAPENEM INJ	INVANZ	Restricted to Infectious Disease Service or local facility equivalent.	FORMULARY
OP201	ERYTHROMYCIN 0.5% OPH OINT	ILOTYCIN	Open Formulary - no restrictions	FORMULARY
DE752	ERYTHROMYCIN 2% TOP GEL	EMGEL	Open Formulary - no restrictions	FORMULARY
DE752	ERYTHROMYCIN 2% TOP SOLN	ERYTHRA DERM	Open Formulary - no restrictions	FORMULARY
AM200	ERYTHROMYCIN 250MG EC TAB	E-MYCIN	Open Formulary - no restrictions	FORMULARY
AM200	ERYTHROMYCIN ETHYLSUCC SUSP 20	EES	Open Formulary - no restrictions	FORMULARY
AM200	ERYTHROMYCIN LACTOBIONATE INJ	ERYTHROCIN	Restrictions per local facility	FORMULARY
CV100	ESMOLOL HCL INJ	BREVIBLOC	Open Formulary - no restrictions	FORMULARY
HS300	ESTRADIOL PATCH	CLIMARA	Estradiol transdermal patches are formulary, restricted to women who have failed or are intolerant to oral estrogens. Recommend that Climara brand be the first-line estradiol transdermal patch for the VISN and Vivelle brand be the preferred non-formulary, second-line estradiol transdermal patch for women who are intolerant to the Climara brand.	FORMULARY
HS300	ESTRADIOL 0.5MG TAB	ESTRACE	Open Formulary - no restrictions	FORMULARY
HS300	ESTRADIOL 1MG TAB	ESTRACE	Open Formulary - no restrictions	FORMULARY
HS300	ESTRADIOL 2MG TAB	ESTRACE	Open Formulary - no restrictions	FORMULARY
HS300	ESTRADIOL INJ	ESTRACE	Open Formulary - no restrictions	FORMULARY
AN900	ESTRAMUSTINE ORAL	EMCYT	Restricted to Oncology Service or local equivalent	FORMULARY
HS300	ESTROGENS CONJUGATED 0.3MG TAB	PREMARIN	Open Formulary - no restrictions	FORMULARY
HS300	ESTROGENS CONJUGATED 0.625MG TAB	PREMARIN	Open Formulary - no restrictions	FORMULARY
HS300	ESTROGENS CONJUGATED 1.25MG TAB	PREMARIN	Open Formulary - no restrictions	FORMULARY
HS300	ESTROGENS CONJUGATED INJ	PREMARIN	Restrictions per local facility	FORMULARY
GU500	ESTROGENS CONJUGATED VAG CREAM	PREMARIN	Open Formulary - no restrictions	FORMULARY
HS300	ESTROGENS,ESTERIFIED ORAL TAB	MENEST	Open Formulary - no restrictions	FORMULARY
CV702	ETHACRYNATE NA INJ	EDECRIN	Restrictions per local facility	FORMULARY
CV702	ETHACRYNIC ACID ORAL	EDACRIN	Open Formulary - no restrictions	FORMULARY
AM500	ETHAMBUTOL 100MG, 400MG TAB	MYAMBUTAL	Open Formulary - no restrictions	FORMULARY
CV600	ETHANOLAMINE OLEATE INJ	ETHAMOLIN	Restrictions per local facility	FORMULARY

HS200	ETHINYL ESTRADIOL 0.12MG/ETONOGESTREL 0.15MG VAG RING	NUVARING	Restricted to Women's Health providers or local facility equivalent.	FORMULARY
HS900	ETHINYL ESTRADIOL 1MG /NORETHINDRONE AC 5MCG ORAL TAB	FEMHRT 1/5	Open Formulary - no restrictions	FORMULARY
HS200	ETHINYL ESTRADIOL 20MCG ORAL	N/A	Open Formulary - no restrictions	FORMULARY
HS200	ETHINYL ESTRADIOL 20MCG/LEVONORGESTREL 0.1MG, 28	EQU-LUTERA	Open Formulary - no restrictions	FORMULARY
HS200	ETHINYL ESTRADIOL 30MCG/LEVONORGESTREL 0.15MG, 28 (MONO)	EQV-LEVLEN	Open Formulary - no restrictions	FORMULARY
HS200	ETHINYL ESTRADIOL 30MCG/LEVONORGESTREL, 28 (TRI)	TRI-LEVLEN	Open Formulary - no restrictions	FORMULARY
HS200	ETHINYL ESTRADIOL 35 MCG/NORGESTIMATE 25 MCG TABLETS, 28, MONO	MONONESSA (EQUIV)	Open Formulary - no restrictions	FORMULARY
HS200	ETHINYL ESTRADIOL 35MCG/NORETHINDRONE 1MG TAB, 21	ORTHO-NOVUM 1/35	Open Formulary - no restrictions	FORMULARY
HS200	ETHINYL ESTRADIOL 35MCG/NORETHINDRONE 1MG TAB, 28	ORTHO-NOVUM 1/35	Open Formulary - no restrictions	FORMULARY
HS200	ETHINYL ESTRADIOL 35MCG/NORETHINDRONE TAB	EQU-NECON 7/7/7	Open Formulary - no restrictions	FORMULARY
HS200	ETHINYL ESTRADIOL/NORGESTIMATE TRIPHASIC ORAL CONTRACEPTIVE	TRINESSA, ORTHO TRI-CYCLEN	Open Formulary - no restrictions	FORMULARY
AM500	ETHIONAMIDE ORAL	TRECATOR-SC	Open Formulary - no restrictions	FORMULARY
DE700	ETHYL CHLORIDE 100% TOP AEROSOL	N/A	Open Formulary - no restrictions	FORMULARY
HS900	ETIDRONATE DISODIUM 200MG TAB	DIDRONEL	Alendronate is open formulary for all indications Alendronate 70mg tablets were added to the formulary to provide two options for weekly dosing: 80mg (two 40mg tablets) or 70mg once a week. Risedronate (Actonel) is non-formulary, available for patients who are intolerant to or fail alendronate therapy. Etidronate is formulary, restricted as second-line therapy.	FORMULARY
HS900	ETIDRONATE INJ	DIDRONEL	Restrictions per local facility	FORMULARY
CN104	ETODOLAC 200MG IR CAP	LODINE	Open Formulary - no restrictions	FORMULARY
CN203	ETOMIDATE INHALATION	AMIDATE	Restrictions per local facility	FORMULARY
AN900	ETOPOSIDE INJ	VEPESID	Restrictions per local facility	FORMULARY
AN900	ETOPOSIDE ORAL	VEPESID	Restricted to Oncology Service or local equivalent	FORMULARY
AM800	ETRAVIRINE ORAL TAB	INTELENCE	Criteria for Use: Etravirine (IntelenceTM) VHA Pharmacy Benefits Management Service and the Medical Advisory Panel FDA APPROVED INDICATION	FORMULARY

			FOR USE Etravirine is indicated in combination with other antiretroviral agents for treatment of HIV-1 infection in antiretroviral treatment-experienced adult patients who have evidence of viral replication and HIV-1 strains resistant to a NNRTI and other antiretroviral agents. EXCLUSION CRITERA (If one is selected, patient is NOT eligible) - HIV-2 - Administration of etravirine in combination with only NRTIs in a patient who previously experienced virologic failure on a NNRTI containing regimen. - Etravirine as part of a multi-drug regimen that includes any of the following: protease inhibitors administered without ritonavir, tipranavir/ritonavir, fosamprenavir/ritonavir, atazanavir/ritonavir, or other NNRTIs INCLUSION CRITERIA (All must be selected for patient to be eligible) - Treatment-experienced patient (defined as 3 class experience including prior or current NNRTI resistance mutation) - Evidence of virologic failure (documented by a viral load >1,000 copies/mL) or intolerant to an individual agent within current antiretroviral regimen - Able to construct a multi-drug regimen that includes, preferably, at least one additional active antiretroviral drug (if available) in addition to etravirine - Under the care of an experienced HIV practitioner DOSAGE AND ADMINISTRATION (Refer to PI for dosage recommendations in organ dysfunction) Etravirine 200mg orally twice daily with food. ** Etravirine drug-drug interactions limit the selection of concomitant antiretrovirals. Suitable regimens may contain combinations of NRTIs with darunavir/ritonavir, saquinavir/ritonavir, enfuvirtide, raltegravir, or maraviroc. Dosage modifications of maraviroc are necessary with co-administration of etravirine. Etravirine may also be used with caution in patients receiving lopinavir/ritonavir.** RECOMMENDED MONITORING In addition to standard monitoring in a patient receiving antiretrovirals, the following is recommended: 1) Baseline and periodic monitoring of LFTs, particularly in patients with pre-existing liver dysfunction or co-infected with viral hepatitis B or C. 2) Baseline and periodic monitoring of total cholesterol, LDL and HDL. - Monitor for rash including severe and potential life-threatening skin reactions; immediately discontinue etravirine if severe hypersensitivity, severe rash or rash with systemic symptoms or liver transaminase elevations develops and monitor clinical status, including liver transaminases closely. ISSUES	

			FOR CONSIDERATION * Careful evaluation for potential drug-drug interactions should be done prior to initiation of etravirine. This agent is substrate of CYP3A4, CYP2C9, and CYP2C19. In addition, etravirine is an inducer of CYP3A4 and inhibitor of CYP2C9 and CYP2C19. * The presence of K103N does not affect etravirine response and the single mutations Y181C/I/V, K101P, and L100I reduce but do not preclude clinical utility. However, the presence of Y181C/I/V, K101H/P, L100I, or three or more 2008 IAS-USA-defined NNRTI substitutions at baseline is associated with a decreased virologic response to etravirine. Hence, it is important to evaluate the presence of other NNRTI mutations beyond the K103N when determining suitability of etravirine for a particular patient. October 2009 VISN 20 P&T Committee . April 2008 VISN 20 P&T Committee	
XA900	EVACUATED CONTAINER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA101	EYE PAD STERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
OP500	EYE RINSE SOLN (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	FACE PLATE	N/A	Open Formulary - no restrictions	FORMULARY
BL500	FACTOR IX COMPLEX, HUMAN	ALPHANINE	Factor IX Complex is restricted to patients with Factor IX deficiency (Hemophilia B) to prevent or control bleeding, or failure to fresh frozen plasma in patients with mild Factor IX deficiency.	FORMULARY
AM800	FAMCICLOVIR ORAL	FAMVIR	Restricted to patients unable to take both acyclovir and valacyclovir.	FORMULARY
GA301	FAMOTIDINE INJ	PEPCID	Open Formulary - no restrictions	FORMULARY
TN300	FAT EMULSION INJ 10% 500ML	N/A	Open Formulary - no restrictions	FORMULARY
TN300	FAT EMULSION INJ 20% 500ML	N/A	Open Formulary - no restrictions	FORMULARY
XA900	FECAL INCONTINENCE COLLECTOR (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA703	FEEDING TUBE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CN400	FELBAMATE ORAL	FELBATOL	Restricted to Neurology Service or local equivalent	FORMULARY
CV200	FELODIPINE 2.5MG, 5MG, 10MG SA TAB	PLENDIL	Clinical Guidance for the Use of Formulary Long-Acting Dihydropyridine Calcium Channel Blockers VHA Pharmacy Benefits Management Strategic Healthcare Group and the Medical Advisory Panel The recommendations are based on current medical evidence and expert opinion from clinicians. The content of the document is dynamic and will be revised	FORMULARY

			as new clinical data become available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. The clinician should utilize this guidance and interpret it in the clinical context of the individual patient. The following recommendations are provided for clinicians considering the use of a formulary long-acting dihydropyridine (LA DHP) calcium channel blocker (CCB) (e.g., amlodipine, felodipine, long-acting nifedipine) for the treatment of hypertension (HTN) and/or angina. Short-acting nifedipine should not be used for these conditions. Hypertension (Amlodipine, Felodipine, or Long-Acting Nifedipine) Thiazide-type diuretics are the preferred first line agents for patients with uncomplicated HTN. In addition, most patients will require more than one agent to control their blood pressure. Another class of medication [e.g., angiotensin-converting enzyme inhibitor (ACEI), long-acting CCB] may be considered in patients who have a contraindication to or are inadequately controlled on a thiazide-type diuretic OR in patients who have an indication for an agent in another antihypertensive class (e.g., beta-blocker in a patient with prior-myocardial infarction or symptomatic coronary ischemia; ACEI and beta-blocker in patients with systolic heart failure). For additional information, refer to www.oqp.med.va.gov for the VHA/DoD Clinical Practice Guideline for Management of Hypertension in Primary Care. A formulary LA DHP may be considered in patients with HTN if they experience/have: - Inadequate control on a thiazide-type diuretic - Documented intolerance to a thiazide-type diuretic - Contraindication to a thiazide-type diuretic - Compelling indication for a LA DHP Angina (Amlodipine, Felodipine, or Long-Acting Nifedipine) Patients with angina should be treated with a beta-adrenergic blocker. A CCB may be an option when a beta-adrenergic blocker alone or in combination with a long-acting nitrate is ineffective or contraindicated. Selection of a non DHP CCB (e.g., diltiazem, verapamil) vs. a long-acting DHP in patients not on a beta-adrenergic blocker may depend on patient specific considerations. If a CCB is being considered in addition to therapy with a beta-adrenergic blocker, the long-acting DHP CCBs are preferred due to the potential for bradycardia or atrioventricular block with a non DHP CCB in combination with a beta-adrenergic blocker. A CCB	

			may also be considered for additional blood pressure control and in patients with variant (Prinzmetal) angina. In addition, it is recommended that all patients with coronary artery disease who also have left ventricular systolic dysfunction and/or diabetes mellitus should be treated with an ACEI, unless contraindicated. For additional information, refer to www.oqp.med.va.gov for the VA/DoD Clinical Practice Guideline for Management of Ischemic Heart Disease. A formulary LA DHP may be considered in patients with angina if they experience/have: - Inadequate control on a beta-adrenergic blocker - Documented intolerance to a beta-adrenergic blocker - Contraindication to a beta-adrenergic blocker - Variant (Prinzmetal) angina and unable to tolerate or do not respond to diltiazem or verapamil Hypertension and/or Angina in Patient with Concomitant Heart Failure (Amlodipine or Felodipine) Patients with systolic HF and concomitant HTN should be maximized on therapy with agents such as diuretics, ACEIs, and beta-adrenergic blockers, and an angiotensin II receptor antagonist (ARB), hydralazine/nitrate, or aldosterone antagonist, as indicated; or beta-adrenergic blockers and long-acting nitrates in patients with concomitant angina, before adding other agents. In patients not adequately controlled on these agents, treatment with amlodipine or felodipine may be considered; these recommendations are based on data in patients with HF treated with amlodipine (patients enrolled in PRAISE on amlodipine included ~ 81% in NYHA class III HF, 19% in class IV, with a mean ejection fraction 21%), and in another trial of patients with HF treated with felodipine (patients evaluated in V-HeFT III on felodipine included ~ 79% patients in NYHA class II HF, 22% in class III, with a mean ejection fraction 29%). The CCBs diltiazem, nifedipine, and verapamil should be avoided in patients with systolic dysfunction. For additional information, refer to www.oqp.med.va.gov for the PBM-MAP Pharmacologic Management of Patients with Chronic Heart Failure. A formulary LA DHP may be considered in the following clinical situations: - For the treatment of HTN in patients with concomitant HF who are not adequately controlled on, or have documented intolerance or a contraindication to a diuretic, ACEI, beta-adrenergic blocker, and ARB, hydralazine, or aldosterone antagonist, as indicated - For the treatment of angina in patients with concomitant HF who are not adequately controlled on, or have documented	

			intolerance or a contraindication to a beta-adrenergic blocker and long-acting nitrate VISN 20 P&T Committee, August 2007	
AU100	FENOLDOPAM MESYLATE INJ	CORLOPAM	Fenoldopam is restricted to cardiothoracic surgery and vascular surgery for patients with two or more of the following: (1) Preexisting renal insufficiency with baseline SCr between 1.4 mg/dL and 2.0 mg/dL; (2) Type 1 Diabetes or screening serum glucose > 300 mg/dL; age > 70 y/o; (3) Recent MI, NYHA class III or IV heart failure; (4) History of major vascular surgery; prolonged cardiopulmonary bypass (>3 hours); (5) Inability to tolerate large volume expansion; and (6) Recent exposure to nephrotoxic agents (e.g., contrast dye, aminoglycosides, etc.) resulting in renal insufficiency (SCr between 1.4 mg/dL and 2.0 mg/dL). Fenoldopam dose for renal protection should be restricted to < 0.1 mcg/kg/min to minimize hypotensive effects. It should be administered throughout the intraoperative period and into the early postoperative period up to 24 hours after the procedure. Patients with history of atrial fibrillation or other arrhythmias and patients who experienced pre-operative hypotension should not use fenoldopam. Fenoldopam is not recommended for use to prevent radiocontrast nephropathy. June 2004, Sept 2006 VISN 20 P&R Committee minutes	FORMULARY
CN101	FENTANYL INJ 0.05MG/ML 2ML, 5ML	SUBLIMAZE	Open Formulary - no restrictions	FORMULARY
CN101	FENTANYL PATCH	DURAGESIC	VA National Criteria for Use: Fentanyl Transdermal Systems Exclusion Criteria Patient should NOT receive transdermal fentanyl if any of the following criteria are met: 0 Use of transdermal fentanyl is for any of the following: (1) mild pain; (2) breakthrough or intermittent pain (i.e., for as-needed / p.r.n. analgesia situations); (3) postoperative pain, including outpatient or day surgeries; and (4) pain due to acute clinical conditions / situations (e.g., acute trauma, new onset herpes zoster / shingles). 0 Patient is not opioid-tolerant, defined as taking less than or equal to 60 mg of morphine daily, 20 mg of methadone daily, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, or an equianalgesic dose of another opioid, for less than one week. 0 Hypersensitivity to fentanyl or local hypersensitivity reaction to any components of the patch that is not adequately controlled with topical medications (e.g., corticosteroids). 0 Patient has a contraindication to opioids (e.g., significant respiratory depression, acute	FORMULARY

			or severe bronchial asthma or hypercarbia, or known or suspected paralytic ileus). Inclusion Criteria Patient must meet all of criteria A-D to use transdermal fentanyl patches. These criteria apply to new starts only; patients stable on transdermal fentanyl should not be required to discontinue it or switch to another opioid unless there is a clinical reason for doing so. A. Patient requires around-the-clock analgesia for moderate to severe, persistent chronic pain B. Patient is followed by a VA or VA-contracted provider for management of transdermal fentanyl therapy. C. Transdermal fentanyl is initially prescribed and titrated by a VA or VA-contracted provider who has experience in dosing transdermal fentanyl or is in consultation with a VA or VA-contracted organized pain clinic or local pain management expert with experience in dosing transdermal fentanyl. D. Patient meets at least one of the following conditions: - is unable to swallow, tolerate, or absorb oral preparations - is unable to adhere to an oral opioid regimen because of cognitive or psychiatric impairment - requires chronic and relatively stable pain management as part of end-of-life care, and twice daily or more frequent oral administration of opioids is likely to be problematic for the patient or caregiver - has a documented current or past history of intolerable adverse effects to long-acting morphine and methadone OR to only long-acting morphine, if methadone is not acceptable because an organized pain clinic or local pain management expert with experience in dosing methadone is not readily available for referral or consultation Intolerable adverse effects are those that persist despite aggressive measures to alleviate them and that prevent upward titration of dosage to achieve a satisfactory level of analgesia (e.g., constipation unresponsive to aggressive use of laxatives; or nausea inadequately controlled by antiemetics or gradual dose titration). Additional Safety Precautions Verify doses. For patients who are admitted to the hospital and using fentanyl patches at home, the dose should be verified during medication reconciliation. Use extra caution with orders for 125-mcg/h patches. Healthcare providers should remain cautious about orders for a 125 mcg/hour strength because the decimal point has been overlooked at times with orders for 12.5 mcg/h patches. When ordering 12.5-mcg/h patches, get into the habit of writing 12 or twelve mcg/h to avoid decimal point confusion. For CPRS orders, consider a pop-up

			reminder asking, Did you really mean one hundred twenty-five mcg/h Assess concomitant use of opioids. To reduce the risk of an overdose, take into consideration any other opioids prescribed for the patient when evaluating the appropriateness of the patient's dose. Do not cut, damage, or alter fentanyl patches prior to application. 1. Do not process orders that require cutting fentanyl patches prior to application. The prescriber must be notified of the hazard as soon as possible. 2. Advise patients receiving fentanyl patches not to cut, damage, or alter the transdermal system before use. 3. Use an alternate opioid therapy when a patient requires transdermal fentanyl in fractions of the patch sizes available. 4. Repeated requests for cutting fentanyl patches prior to application should be referred to the Pharmacy Manager for review by the facility Medication Use or Pharmacy and Therapeutics Committee. Remove previous patches before applying the next dose. This is especially important in inpatient settings. Check the patient carefully, including in skin folds, and remove old fentanyl patches before applying a new patch. Providers may encourage patients to place patches in view on the front torso or upper arms so they can be seen when looking in the mirror. Avoid external heat on patch application site. All patients and their caregivers should be advised to avoid exposing the fentanyl patch application site to direct external heat sources, such as heating pads or electric blankets, heat lamps, saunas, hot tubs, and heated water beds, etc., while wearing the system. Avoid taking hot baths and sunbathing. Patients who develop fever or increased core body temperature (e.g., from strenuous exertion) should be monitored for opioid toxicity. There is a potential for temperature-dependent increases in fentanyl released from the system resulting in possible overdose and death. Remove fentanyl transdermal patches prior to MRI. Advise patients to remove the patch temporarily during MRI and replace with a new one after the procedure (ISMP Medication Safety Alert, April 8th, 2004; http://www.ismp.org/ Newsletters/acutecare/articles/20040408.asp) Reduce the dose of fentanyl or CNS depressants when used concomitantly. The concomitant use of fentanyl transdermal system with other central nervous system depressants, including but not limited to other opioids, sedatives, hypnotics, tranquilizers (e.g., benzodiazepines), general anesthetics, phenothiazines,

			skeletal muscle relaxants, and alcohol, may cause respiratory depression, hypotension, and profound sedation or potentially result in coma. When such combined therapy is contemplated, the dose of one or both agents should be significantly reduced. Use caution with concomitant CYP3A4 inhibitors. Patients receiving transdermal fentanyl and potent CYP3A4 inhibitors (e.g., clarithromycin, itraconazole, ketoconazole, nefazodone, ritonavir, troleandomycin) should be carefully monitored for an extended period of time and dosage adjustments should be made if warranted, particularly when CYP3A4 inhibitors are added to existing transdermal fentanyl therapy or when the dose of a CYP3A4 inhibitor is increased. Use extra caution when converting to or from fentanyl patches. Overestimating the transdermal fentanyl dose when converting patients from another opioid medication to transdermal fentanyl patches can result in fatal overdose with the first dose. The conversion table in the Package Insert is unidirectional (i.e., from other opioids TO transdermal fentanyl). Do not use the conversion table in the Package Insert to convert patients FROM transdermal fentanyl to other opioids because the dosing table is conservative and may result in opioid toxicity if used in this manner. Provide and document mandatory patient education. Educate patient and / or caregiver on how to use the transdermal fentanyl patch; provide and review the patient Medication Guide, and document this mandatory education in the patient's medical record. Also provide and view the Patient Instructions for Use.1 In inpatient and outpatient settings, the discussion should include, at the minimum, indications; high potency; dose; safety precautions (e.g., avoid heating pads or hot tubs, remove old patch before application of a new patch); application, removal, and disposal processes; and signs of fentanyl toxicity. Emphasize the need to store medication in a locked secure place at work and home, out of the reach of children (and pets); the potential for fatal respiratory depression from fentanyl that still remains in used patches; and the suggestion to avoid application of the patch in front of children since children sometimes imitate adults. Pharmacists could use this counseling opportunity to verify that the patient is opioid-tolerant and being treated for chronic pain. Allow adequate time for recovery from any fentanyl toxicity. Because the mean elimination half-life of transdermal fentanyl is 17 hours,

			patients who are thought to have had a serious adverse event, including overdose, will require monitoring and treatment for at least 24 hours after removal of patch (es). Inform pregnant and lactating women that fentanyl may be harmful to babies. There are no adequate and well-controlled studies in pregnant women (Pregnancy Category C). Use fentanyl during pregnancy only if the potential benefit justifies the potential risk to the fetus. Fentanyl is not recommended for analgesia during labor and delivery. Fentanyl is not recommended for use in nursing women because of potential risks to their infants. Consult Product Information for further information. DOSING AND ADMINISTRATION Additional dosing information can be found in the Fentanyl Transdermal Patch Dosing and Safety Information Paper available at the VHA Pain Management Web site: http://www1.va.gov/Pain_Management/. Initial Dose - Transdermal fentanyl should NOT be used in opioid-naive persons. It should only be started in patients who are opioid-tolerant; therefore, the initial dose is actually an initial conversion dose. See table for initial conversion doses below. - Initial conversion doses should be individualized. Conversion dosage requirements can vary widely between individuals and therefore it is difficult to recommend a fixed method for conversion. The patient's medical condition, the potency, dose, and type of previous opioid, the patient's degree of opioid exposure and tolerance, the patient's past analgesic response and adverse experiences, and the accuracy and reliability of opioid conversion factors may all influence the choice of starting dose. - Overestimating the transdermal fentanyl dose when converting patients from another opioid can result in fatal overdose with the first dose. - Use caution in elderly, cachectic or debilitated patients as they may have altered pharmacokinetics due to poor fat stores, muscle wasting, or altered clearance - Since there is a delay in analgesic effects after the initial patch application, providers should consider providing the patient with short-acting analgesics to take on an as-needed basis until the patient achieves sufficient analgesic effects from the fentanyl patch (1 to 2 days) Conversion of an oral opioid medication TO transdermal fentanyl - Table 1 conversions are unidirectional. Use Table 1 to convert patients from other opioids TO transdermal fentanyl only. Do not use this table to convert patients from transdermal fentanyl	

			to other opioids; doing so may result in fentanyl overdose and toxicity. Table 1 INITIAL CONVERSION DOSE OF TRANSDERMAL FENTANYL PATCH BASED UPON DAILY DOSE OF CURRENT OPIOID Current Oral Opioid Daily Dose (mg/d) Codeine p.o. 150-447 448-747 748-1047 1048-1347 Hydrocodone p.o. 60 -- -- -- Hydromorphone p.o. 8-17 17.1-28 28.1-39 39.1-51 Levorphanol p.o. 8-17 17.1-28 28.1-39 39.1-51 Methadone p.o. 20-44 45-74 75-104 105-134 Morphine p.o. 60-134 135-224 225-314 315-404 Oxycodone p.o. 30-67 67.5-112 112.5-157 157.5-202 Oxymorphone p.o. 20-44 45-74 75-104 105-134 Recommended Dose of Transdermal Fentanyl Patch 25mcg/h 50mcg/h 75mcg/h 100mcg/h Source: Duragesic Product Information, 2/08; Opana (oxymorphone ER) Product Information, 2/08 According to this conversion table, every 90 mg/d (range, 60-134 mg/d) of oral morphine or equivalent converts to approximately 25 mcg/h of transdermal fentanyl (but not necessarily vice versa). Dosage conversions are only approximate. Refer to Package Insert or other appropriate references for alternative dose conversion methods. Refer to product information on transdermal fentanyl for converting from non-oral opioids to transdermal fentanyl. Conversion FROM transdermal fentanyl to another opioid - There is a lack of evidence-based guidance on switching patients from transdermal fentanyl to other opioids. - The Product Information for oxycodone CR (OxyContinr, 2007) suggests starting oxycodone CR 18 hours after removal of the transdermal fentanyl patch, using a conservative oxycodone dose of approximately 10 mg q12h of oxycodone CR for each 25 mcg/h transdermal fentanyl patch. - After discontinuing the fentanyl patch, carefully titrate the new opioid according to the patient's clinical response, using conservative initial doses and dosage conversion ratios, and taking into consideration that serum fentanyl concentrations derived from the patch decrease by 50% every 17 hours (range, 13-22 hours). As suggested for oxycodone CR, one approach is to start the new opioid about 18 hours after the fentanyl patch has been removed. - Providers inexperienced in converting patients from transdermal fentanyl to another opioid should consult a clinician who has experience in dosing transdermal fentanyl Dose Titration - The initial conversion doses shown in Table 1 above are conservative and large interpatient variability in the conversion dose exists. Further dose adjustment	

			may be needed. - Short-acting analgesics should also be considered for predictable, incident breakthrough pain. - Individualize dosing frequency and assess dosage modifications on a regular basis. The dose of transdermal fentanyl may be increased on the basis of average daily use of supplemental opioid analgesic but dosage increases should generally not be increased sooner than 3 days after the initial dose or more frequently than every 6 days (i.e., after 2 patch applications) thereafter. Some patients require patches to be applied every 2 days (48 hours) instead of every 3 days (72 hours) to achieve adequate analgesia. An increase in the transdermal fentanyl dose should be evaluated before changing dosing intervals in order to maintain patients on a 72-hour regimen. - Appropriate dosage increments should be based on the daily use of supplemental opioids with the equivalency of morphine 45 mg/d orally to a 12 mcg/h increase in the transdermal fentanyl dose. Transdermal fentanyl-12 delivers 12.5 mcg/h of fentanyl. Guidance on High-dose Transdermal Fentanyl - Patients requiring transdermal fentanyl doses greater than 200 mcg/h should be evaluated by a specialist in pain management, anesthesiology, palliative care, or hematology/oncology Suggestions on Perioperative Use - Pain experts suggest continuing transdermal fentanyl throughout the perioperative period (e.g., for inpatient and outpatient post-operative pain). Abrupt discontinuation of the patch in the perioperative period may lead to opioid withdrawal or uncontrolled post-operative pain. August 2008 VISN 20 P&T Committee	
TN401	FERRIC NA GLUCONATE COMPLEX 12.5MG/ML INJ	FERRLECIT	Open Formulary - no restrictions	FORMULARY
TN401	FERROUS GLUCONATE ORAL	FERGON	Ferrous gluconate is the second line formulary oral iron supplement, restricted to patients unable to take ferrous sulfate	FORMULARY
TN401	FERROUS SULFATE 325MG TAB	FEOSOL	Open Formulary - no restrictions	FORMULARY
TN401	FERROUS SULFATE ELIXIR 220MG/5ML	FEOSOL	Open Formulary - no restrictions	FORMULARY
BL400	FILGRASTIM 300MCG/ML INJ	NEUPOGEN	NORTHWEST NETWORK (VISN 20) COLONY STIMULATING FACTOR (CSF) USAGE GUIDELINES: A. INDICATIONS [see below for Hep C criteria] 1. Patients with AIDS a. Absolute Neutrophil Count (ANC) less than 1,000 and with acute infection. b. ANC less than 500, and with history of a moderately severe bacterial or fungal infection. c. ANC less than 250. d.	FORMULARY

			Any AIDS patient immediately following therapy for lymphoma. 2. Patients with severe constitutional neutropenia arising from bone marrow failure states other than acute myelogenous leukemia. Possible diagnoses include congenital neutropenia, cyclic neutropenia, hairy cell leukemia and aplastic anemia. 3. Patients with cancer: Patients should be treated with colony stimulating factor only when: a. There is an expectation for cure or prolonged disease-free survival as the result of a specific myelosuppressive therapy, and b. It is known that normal dose intensity is an important factor in a given case (from published literature or empirically), and c. One of the following: 1. There has been one prior episode of severe myelosuppression or the patient has AIDS or is over 65 years of age or there is an expected incidence of febrile neutropenia > 40%. 2. There has been a documented febrile neutropenia in a prior chemotherapy cycle. 3. In patients with newly diagnosed AML, GM-CSF (Sargramostim) may be used after completion of induction chemotherapy (particularly in patients > 55 years of age). 4. Patients with myelodysplastic syndromes who have severe anemia and/or are red blood cell transfusion dependent may benefit from a trial of G-CSF combined with recombinant human erythropoietin. B. AUTHORITY TO PRESCRIBE: Prescriptions for Colony Stimulating Factors require approval by a full-time physician from Hematology-Oncology or Infectious Disease Service within the Northwest Network. C. DOSING GUIDELINES: 1. Colony Stimulating Factors will not be administered 24 hours before or after a course of chemotherapy. 2. Therapy with G-CSF will be initiated with 5 mcg/kg subcutaneously daily for up to 2 weeks with routine motoring (twice weekly) of neutrophil counts, CBC and platelets. 3. CSFs may be given IV if subcutaneous dosing will result in undue bruising secondary to thrombocytopenia. 4. G-CSF will be administered to the day of recovery (ANC>500) of the first cycle or 2 days prior to that day and then stopped if the patient is afebrile (most treatment periods will be for 14-21 days). In general, those patients who fail to demonstrate a 2-3 fold increase in neutrophil count after 5 days of therapy can be increased immediately to 10 mcg/kg for 4 additional days. Those patients not responding after this dosage increase should be considered non-responders and therapy should be discontinued. The determination that a patient is a non-responder is at the	

			judgment of the treating clinician and is not limited to a prescribed number of days or doses 5. GM-CSF for myelosuppressive chemotherapy-associated neutropenia (FDA approval pending) is initiated at a dose of 250 mcg/m2 subcutaneously each day following the guidelines listed for G-CSF listed. 6. Any increase in dosage with GM-CSF should be done cautiously because of reported dose-related toxicity with this agent. Caution should be used for doses that exceed 500 mcg/m2 daily. 7. Dosage adjustments should be made based on patient response to therapy. If the ANC>2000 (prior to the day of first course recovery) the dose should be decreased by 50% and maintained for 48 hours before further decreases or stoppage D. MARROW TRANSPLANT PROGRAM USAGE: 1. CSF Usage Guidelines are developed in conjunction with Bone Marrow Transplant approved therapeutic protocols. 2. Clinical use of CSFs in autologous and allogeneic stem cell transplant is continuously under assessment, and use on the Marrow Transplant Unit (MTU) requires approval by the MTU attending physician. 3. Use of CSFs in MTU patients with poor engraftment may be approved by the MTU attending physician. ---------- Granulocyte Stimulating Colony Factor Criteria for Use for Hepatitis C Treatment-Related Neutropenia Patient Selection Before using a granulocyte colony stimulating factor: * Peginterferon dose has been reduced o Peginterferon alfa 2a reduction from 180mcg/week to 135mcg/week o Peginterferon alfa 2b reduction from 1.5mcg/kg/week to 1.0mcg/kg/week AND * Persistent severe neutropenia despite at least 2 weeks of reduced dose peginterferon along with: o ANC 500/mm3) * Maintain therapeutic dose of interferon-based preparation (generally, dose reductions of up to 40% do not appear to compromise SVR) * Reduced risk of infection and hospitalization Dosing and Monitoring (Refer to algorithm) * Filgrastim 300 mcg sq once or twice a week. * Titrate filgrastim dose to achieve ANC 500-1000/mm3. * Check nadir ANC just prior to the next dose to evaluate response every 1-2 weeks until stable * If ANC shows no increase or continues to decrease after at least 1 week of filgrastim, then further reduce or discontinue peginterferon and titrate filgrastim as above. o Investigate other potential cause for neutropenia (e.g., myelodysplasia) * If ANC >1000/mm3, stop filgrastim. for algorithm, please see: http://vaww.pbm.va.gov/criteria/GSCFCriteriaForUsefor	

			HepatitisC.pdf National CFU - March 2006 VISN 20 P&T Committee April 21, 2006	
BL400	FILGRASTIM FOR HEPATITIS C TREATMENT		FORMULARY,CFU	FORMULARY
XA859	FILTER NEEDLE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
HS900	FINASTERIDE 5MG TAB	PROSCAR	FINASTERIDE CRITERIA FOR USAGE - Finasteride is formulary, restricted VA National Criteria: (1) Patients currently receiving monotherapy with an alpha-blocker at maintenance doses (e.g., doxazosin 8 mg qd, prazosin 4 mg BID, terazosin 10 mg qd, tamsulosin 0.4 mg qd or alfuzosin 10mg qd) or at highest tolerated dose if maintenance dose was not achieved, who have a large prostate (typically >40ml, or approximately the size of a golf ball)* and either (a) Clinical progression of BPH symptoms as suggested by either an increase in the AUA symptom score ?4 points from baseline or a history of acute urinary retention OR (b) Persistently bothersome symptoms despite adequate alpha-blocker therapy, as above* OR (2) Patients who have not tried an alpha-blocker, but have symptoms of benign prostatic hypertrophy who have a baseline AUA score of ?12 and who are at high risk for an intervention or urinary retention because of a large prostate volume (typically >40ml, or approximately the size of a golf ball) * *The risks and benefits of long-term finasteride therapy should be discussed with the patient. At this time finasteride is not recommended for prevention of prostate cancer based on the Prostate Cancer Prevention Trial. Patients should be reevaluated on a regular basis. Feb 2007 VISN 20 P&T Committee	FORMULARY
XA900	FINGER COT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CV300	FLECAININDE ORAL TABLET	TAMBOCOR	Initial prescriptions must be approved by Cardiology with documentation of the indication and treatment goals. Renewals require an annual Cardiology review. July 2009	FORMULARY
AM700	FLUCONAZOLE INJ	DIFLUCAN	Open Formulary - no restrictions	FORMULARY
AM700	FLUCONAZOLE ORAL	DIFLUCAN	Open Formulary - no restrictions	FORMULARY
AM700	FLUCYTOSINE ORAL	ANCOBON	Restricted to ID Service or local equivalent	FORMULARY
AN300	FLUDARABINE INJ	FLUDARA	Restrictions per local facility	FORMULARY
HS052	FLUDROCORTISONE ACETATE 0.1MG	FLORINEF	Open Formulary - no restrictions	FORMULARY
AD900	FLUMAZENIL INJ	ROMAZICON	Open Formulary - no restrictions	FORMULARY

NT200	FLUNISOLIDE NASAL INHALER	NASALIDE	Open Formulary - no restrictions	FORMULARY
RE101	FLUNISOLIDE ORAL INHALER	AEROBID	(1) Mometasone (Asmanex) is formulary, the first line oral steroid inhaler (2) Flunisolide (Aerobid) is formulary, second line. (3) All other oral corticosteroid inhalers are non-formulary. June 16th 2006 VISN 20 P&T Committee	FORMULARY
DE200	FLUOCINOLONE ACETONIDE 0.01% TOP SOLN	SYNALAR	Open Formulary - no restrictions	FORMULARY
DE200	FLUOCINONIDE 0.05% CREAM	LIDEX	Open Formulary - no restrictions	FORMULARY
DE200	FLUOCINONIDE 0.05% OINT	LIDEX	Open Formulary - no restrictions	FORMULARY
OP900	FLUORESCEIN NA /PROPARACAINE OPH SOLN	FLUORACAINE	Open Formulary - no restrictions	FORMULARY
OP900	FLUORESCEIN NA INJ	FLUORESCITE	Open Formulary - no restrictions	FORMULARY
OP900	FLUORESCEIN OPHTH STRIP	FLUOR-I-STRIP	Open Formulary - no restrictions	FORMULARY
DE700	FLUORI-METHANE TOP SPRAY 120ML	FLUORI-METHANE	Open Formulary - no restrictions	FORMULARY
OP300	FLUOROMETHOLONE OPH SUSP	FML	Open Formulary - no restrictions	FORMULARY
AN300	FLUOROURACIL INJ	ADRUCIL	Restrictions per local facility	FORMULARY
DE600	FLUOROURACIL TOP SOLN	EFUDEX	Open Formulary - no restrictions	FORMULARY
DE600	FLUOROURACIL TOPICAL CREAM	EFUDEX	Open Formulary - no restrictions	FORMULARY
CN609	FLUOXETINE ORAL	PROZAC	Open Formulary - no restrictions	FORMULARY
HS100	FLUOXYMESTERONE ORAL	HALOTESTIN	Restricted to Endocrinology or local equivalent	FORMULARY
CN701	FLUPHENAZINE DECANOATE INJ 25M	PROLIXIN	Restrictions per local facility	FORMULARY
CN701	FLUPHENAZINE HCL 1MG, 2.5MG, 5MG TAB	PROLIXIN	Open Formulary - no restrictions	FORMULARY
CN701	FLUPHENAZINE HCL ELIXIR 2.5MG/5ML	PROLIXIN	Open Formulary - no restrictions	FORMULARY
CN701	FLUPHENAZINE HCL ORAL CONC 5MG/ML	PROLIXIN	Open Formulary - no restrictions	FORMULARY
DE200	FLURANDRENOLIDE 4MCG/SQCM TAPE	CORDRAN	Open Formulary - no restrictions	FORMULARY
OP900	FLURBIPROFEN NA OPH SOLN	OCUFEN	Open Formulary - no restrictions	FORMULARY
AN900	FLUTAMIDE ORAL CAP	N/A	Open Formulary - no restrictions	FORMULARY
NT200	FLUTICASONE PROPRIONATE NASAL INHALATION	FLONASE	Open Formulary - no restrictions	FORMULARY
VT102	FOLIC ACID 1MG TAB	FOLVITE	Open Formulary - no restrictions	FORMULARY
VT102	FOLIC ACID INJ 5MG/ML 10ML	FOLVITE	Open Formulary - no restrictions	FORMULARY
AD900	FOMEPIZOLE INJ	ANTIZOL	Open Formulary - no restrictions	FORMULARY

BL100	FONDAPARINUX INJ	ARIXTRA	VA National Criteria for Use: Fondaparinux (Arixtra)1 FDA APPROVED INDICATIONS FOR USE - Venous Thromboembolism (VTE) prophylaxis: Fondaparinux has demonstrated greater or equivalent efficacy to low-molecular weight heparin (LMWH) in VTE prophylaxis for major orthopedic procedures and abdominal surgery. - VTE Treatment (deep venous thrombosis [DVT] and pulmonary embolism [PE]): Fondaparinux has demonstrated similar efficacy to LMWH and unfractionated heparin (UFH). EXCLUSION CRITERIA (If one is selected, patient is NOT eligible) 0 Creatinine clearance 100 kg, respectively MONITORING 0 Patients should be monitored for signs and symptoms of bleeding. 0 Platelet count should be checked at baseline and monitored periodically thereafter. 0 Renal function should be assessed at baseline and monitored periodically thereafter. ISSUES FOR CONSIDERATION 0 Fondaparinux should be used with caution in the following populations: patients >75 years of age or those with low body weight or impaired renal function, as increased risk of bleeding has been demonstrated. 0 Overdose with fondaparinux is not reversible with protamine sulfate. 0 Given the relatively long half-life of fondaparinux (17 hrs) and the inability for anticoagulation reversal, the drug should not be used in patients where emergent anticoagulation reversal may be necessary or where inability of anticoagulation reversal could have detrimental consequences (examples may include neurosurgery, acute trauma, or acute spinal cord injury patients). 0 Duration of thromboprophylaxis was up to 11 days in clinical trials. However, benefits of prolonged duration of VTE prophylaxis have been documented. 0 Recommended duration for thromboembolism treatment is at least 5 days and until oral anticoagulation is within the therapeutic range. VISN 20 P&T Committee August 2008	FORMULARY

RE102	FORMOTEROL CAP FOR INHALATION	FORADIL	VISN 20 Formoterol Criteria for Use: 1. Restricted to use in patients with a diagnosis of COPD or asthma who have one or more of the following: (a) Nocturnal symptoms; (b) Frequent need for PRN rescue medications (greater than 12 inhalations per day of a short-acting beta-2 agonist); (c) Persistent asthma symptoms with concurrent use of inhaled corticosteroid therapy; (d) Predictable exercise-induced symptoms requiring use of a short-acting beta-2 agonist. 2. Pharmacists should educate patients that long-acting beta-2 agonists are not intended for acute attacks, and label the medication appropriately. 3. Patients should have a concurrent prescription for a short-acting agent to use as a rescue medication. 4. Maximum fill of one device per month (60 doses). 5. The use of formoterol is absolutely contraindicated without the use of an asthma controller medication, typically an inhaled corticosteroid, in patients with asthma. Single-ingredient formoterol should only be used in combination with an asthma controller medication; it should not be used alone. VISN 20 Salmeterol Non-Formulary Criteria for Use: 1. Restricted to patients intolerant to formoterol. 2. Pharmacists should educate patients that long-acting beta-2 agonists are not intended for acute attacks, and label the medication appropriately. 3. Patients should have a concurrent prescription for a short-acting agent to use as a rescue medication. 4. Maximum fill of one device per month (60 doses). 5. The use of salmeterol is absolutely contraindicated without the use of an asthma controller medication, typically an inhaled corticosteroid, in patients with asthma. Single-ingredient salmeterol should only be used in combination with an asthma controller medication; it should not be used alone. May 2004, Sept 2006, June 2008, Mar 2010, May 2010 VISN 20 P&T Committee	FORMULARY
AM800	FOSAMPRENAVIR ORAL TAB	LEXIVA	Restricted to HIV prescribers	FORMULARY
OP900	FOSCARNET NA INJ	FOSCAVIR	Restricted to ID Service or local equivalent	FORMULARY
CV800	FOSINOPRIL 10MG, 20MG TAB	MONOPRIL	Fosinopril is formulary, fourth-line ACEI after captopril, lisinopril, and enalapril. Oct 2004	FORMULARY
CN400	FOSPHENYTOIN NA INJ	CEREBYX	Restrictions per local facility	FORMULARY
CV702	FUROSEMIDE 20MG, 40MG, 80MG TAB	LASIX	Open Formulary - no restrictions	FORMULARY
CV702	FUROSEMIDE INJ 10MG/ML 2ML	LASIX	Open Formulary - no restrictions	FORMULARY

CN400	GABAPENTIN ORAL CAPSULE	NEURONTIN	Open Formulary - no restrictions	FORMULARY
DX900	GADOBENATE DIMEGLUMINE INJ	MULTIHANCE	Gadobenate dimeglumine is Formulary, restricted to Radiology for Angiographic procedures. Gadoteridol is the first-line agent for all other MRI procedures. April 2007	FORMULARY
DX102	GADOPENTETATE DTPA INJ	MAGNEVIST	Open Formulary - no restrictions	FORMULARY
DX900	GADOTERIDOL INJ	PROHANCE	Gadobenate dimeglumine is Formulary, restricted to Radiology for Angiographic procedures. Gadoteridol is the first-line agent for all other MRI procedures. April 2007	FORMULARY
CN900	GALANTAMINE HYDROBROMIDE ORAL (SA CAPS AND RR TABS)	RAZADYNE (REMINYL=OLD NAME)		FORMULARY
AM800	GANCICLOVIR INJ	CYTOVENE	Restrictions per local facility	FORMULARY
OP203	GANCICLOVIR OPH IMPLANT	VITRASERT	Use of ganciclovir implants requires concurrence from Infectious Disease Service to assure implant use is associated with CMV infections and that alternatives have been investigated.	FORMULARY
XA109	GAUZE ELASTIC STERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA103	GAUZE ADAPTIC (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA101	GAUZE DRESSING 2X2IN STERILE #	N/A	Open Formulary - no restrictions	FORMULARY
XA101	GAUZE DRESSING 4X4IN STERILE #	N/A	Open Formulary - no restrictions	FORMULARY
XA109	GAUZE ELASTIC NONSTERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA103	GAUZE NON-ADHESIVE PETROLATUM	N/A	Open Formulary - no restrictions	FORMULARY
XA111	GAUZE PACKING PLAIN	N/A	Open Formulary - no restrictions	FORMULARY
XA101	GAUZE PAD 2IN X 2IN STERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA101	GAUZE PAD 4IN X 4IN STERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA102	GAUZE PAD NONSTERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA102	GAUZE PAD NONSTERILE(OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA101	GAUZE PAD STERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA109	GAUZE,ELASTIC (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA106	GAUZE,FINE MESH STERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA103	GAUZE,PETROLATUM (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
BL300	GELATIN FILM, ABSORBABLE 100X125	N/A	Open Formulary - no restrictions	FORMULARY
OP900	GELATIN,ABSORBABLE	N/A	Open Formulary - no restrictions	FORMULARY

AN900	GEMCITABINE INJ	GEMZAR	Restrictions per local facility	FORMULARY
CV350	GEMFIBROZIL 600MG TAB	LOPID	Open Formulary - no restrictions	FORMULARY
AM300	GENTAMICIN INJ 40MG/ML 2ML INJ, 20ML MDV	GARAMYCIN	Restrictions per local facility	FORMULARY
OP201	GENTAMICIN OPHTHALMIC SOLN	GARAMYCIN	Open Formulary - no restrictions	FORMULARY
OP201	GENTAMICIN SO4 OPH OINT	GARAMYCIN	Open Formulary - no restrictions	FORMULARY
DE101	GENTAMICIN SULFATE CREAM	GARAMYCIN	Open Formulary - no restrictions	FORMULARY
OP350	GENTAMICIN/PREDNISOLONE OPH SUSP	PRED-G	Open Formulary - no restrictions	FORMULARY
DE109	GENTIAN VIOLET 1% TOP SOLN (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE109	GENTIAN VIOLET 2% TOP SOLN (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
IM900	GLATIRAMER ACETATE INJ	COPAXONE	Interferon beta-1a (Avonex and Rebif), Interferon beta-1b (Betaseron), and Glatiramer (Copaxone) are all formulary with the following restrictions: Restricted to Neurology Services, Physical Medicine and Rehabilitation Services, Multiple Sclerosis Clinic or local facility equivalent. Initiation and Treatment Criteria as follows: Initiation Criteria: a. Initiation of therapy is advised as soon as possible following a definite diagnosis of MS and determination of a relapsing course. b. Patients' access to medication should not be limited by the frequency of relapses, age, or level of disability. Treatment Criteria: a. Patients should not be treated with both glatiramer and a beta interferon concurrently. b. The effectiveness and continued treatment will be determined by the treating prescriber. Patients will be re-evaluated every two years to determine continued effectiveness of treatment February 2000, May 2003	FORMULARY
HS502	GLIPIZIDE 10MG TAB	GLUCOTROL	Open Formulary - no restrictions	FORMULARY
HS502	GLIPIZIDE 5MG TAB	GLUCOTROL	Open Formulary - no restrictions	FORMULARY
IM500	GLOBULIN,IMMUNE INJ	N/A	Open Formulary - no restrictions	FORMULARY
XA900	GLOVE LATEX NONSTERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	GLOVE LATEX STERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	GLOVE VINYL LARGE NONSTERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	GLOVE VINYL MEDIUM NONSTERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
HS503	GLUCAGON 1MG/VI INJ	N/A	Open Formulary - no restrictions	FORMULARY
HS503	GLUCOSE CHEW TAB (OTC)	N/A	Open Formulary - no restrictions	FORMULARY

DX900	GLUCOSE KETONE TEST STRIP	KETODIASTIX	Open Formulary - no restrictions	FORMULARY
DX900	GLUCOSE TOLERANCE TEST BEVERAGE 10OZ	N/A	Open Formulary - no restrictions	FORMULARY
HS502	GLYBURIDE 2.5MG TAB	DIABETA	Open Formulary - no restrictions	FORMULARY
HS502	GLYBURIDE 5MG TAB	DIABETA	Open Formulary - no restrictions	FORMULARY
RS300	GLYCERIN SUPP	N/A	Open Formulary - no restrictions	FORMULARY
IR100	GLYCINE IRRIGATION SOLN	AMINOACETIC ACID IRRIGATION SOLN	Open Formulary - no restrictions	FORMULARY
DE900	GLYCOLIC ACID 12% LOTION (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
AU350	GLYCOPYRROLATE INJ 0.2MG/ML 1M	ROBINUL	Open Formulary - no restrictions	FORMULARY
MS160	GOLD NA THIOMALATE INJ	MYOCHRYSINE	Restricted to Rheumatology or Local facility equivalent	FORMULARY
AN500	GOSERELIN ACETATE IMPLANT SYRINGE	ZOLADEX	Restricted to Oncology and Urology Services or local facility equivalents.	FORMULARY
OP209	GRAMICIDIN/NEOMYCIN/POLYMYXIN OPH SOLN	NEOSPORIN	Open Formulary - no restrictions	FORMULARY
RE302	GUAIFENESIN 100MG/5ML SYRUP	ROBITUSSIN	Open Formulary - no restrictions	FORMULARY
RE302	GUAIFENESIN ORAL	HUMIBID	Open Formulary - no restrictions	FORMULARY
XA112	GUAZE PACKING, MEDICATED (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
IM100	HAEMOPHILUS B CONJUGATE VACCINE	ACTHIB	Open Formulary - no restrictions	FORMULARY
CN709	HALOPERIDOL 0.5, 1, 2, 5, 10, 20MG TAB	HALDOL	Open Formulary - no restrictions	FORMULARY
CN709	HALOPERIDOL DECANOATE INJ	HALDOL	Open Formulary - no restrictions	FORMULARY
CN709	HALOPERIDOL INJ 5MG/ML 1ML	HALDOL	Open Formulary - no restrictions	FORMULARY
CN709	HALOPERIDOL ORAL CONC 2MG/ML	HALDOL	Open Formulary - no restrictions	FORMULARY
CN201	HALOTHANE 125ML	FLUOTHANE	Open Formulary - no restrictions	FORMULARY
DE900	HAMAMELIS WATER 50% TOP PAD (OTC)	TUCKS	Open Formulary - no restrictions	FORMULARY
OT250	HC 1%/NEOMYCIN 3.5MG/POLYMYXIN OTIC	CORTISPORIN	Open Formulary - no restrictions	FORMULARY
CV704	HCTZ 50/TRIAMTERENE 75MG TAB	MAXZIDE	Open Formulary - no restrictions	FORMULARY
DX900	HEMA-CHEK OCCULT BLOOD SLIDE TEST (OTC)	HEMA-CHEK	Open Formulary - no restrictions	FORMULARY
DX900	HEMATEST TAB (NOT FOR ORAL USE) (OTC)	HEMATEST	Open Formulary - no restrictions	FORMULARY
RS201	HEMORRHOIDAL RTL OINT (OTC)	PREPARATION H	Open Formulary - no restrictions	FORMULARY
RS201	HEMORRHOIDAL RTL SUPP	PREPARATION H	Open Formulary - no restrictions	FORMULARY
BL100	HEPARIN 1000 UNIT/ML INJ 1ML, 30ML	N/A	Open Formulary - no restrictions	FORMULARY
BL100	HEPARIN 20,000 UNIT/ML INJ 1M	N/A	Open Formulary - no restrictions	FORMULARY

BL100	HEPARIN NA 5000 UNT/ML INJ	N/A	Open Formulary - no restrictions	FORMULARY
IM100	HEPATITIS A VACCINE INJ	HAVRIX	Open Formulary - no restrictions	FORMULARY
IM100	HEPATITIS A/HEPATITIS B VACCINE INJ	TWINRIX	Open Formulary - no restrictions	FORMULARY
IM500	HEPATITIS B IMMUNE GLOBULIN INJ	BAYHEP B/ NABI-HB	Open Formulary - no restrictions	FORMULARY
IM100	HEPATITIS B VACCINE 20MCG/ML 1ML VIAL	RECOMBIVAX B	Open Formulary - no restrictions	FORMULARY
BL800	HETASTARCH 6% IN LACTATED ELECTROLYTE INJ	HEXTEND	Open Formulary - no restrictions	FORMULARY
BL800	HETASTARCH INJ	HESPAN	Open Formulary - no restrictions	FORMULARY
OP500	HIGH VISCOSITY ARTIFICIAL TEARS (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DX300	HISTOPLASMIN 1:100 SKIN TEST INJ	N/A	Open Formulary - no restrictions	FORMULARY
OP600	HOMATROPINE HYDROBROMIDE OPH SOLN	ISOPTO HOMATROPINE	Open Formulary - no restrictions	FORMULARY
XA900	HOSE ANTI-EMBOLISM (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
OP900	HYALURONATE NA OPH INJ	HEALON INJ	Open Formulary - no restrictions	FORMULARY
CV490	HYDRALAZINE HCL 10MG TAB	APRESOLINE	Open Formulary - no restrictions	FORMULARY
CV490	HYDRALAZINE HCL 25MG, 50MG TAB	APRESOLINE	Open Formulary - no restrictions	FORMULARY
CV490	HYDRALAZINE INJ 20MG/ML 1ML	APRESOLINE	Open Formulary - no restrictions	FORMULARY
CV701	HYDROCHLOROTHIAZIDE ORAL TAB/CAPSULE	HYDRODIURIL	Open Formulary - no restrictions	FORMULARY
CV400	HYDROCHLOROTHIAZIDE/LISINOPRIL ORAL TAB	PRINZIDE	Open Formulary - no restrictions	FORMULARY
CV400	HYDROCHLOROTHIAZIDE/SPIRONOLACTONE ORAL TAB	ALDACTAZIDE	Open Formulary - no restrictions	FORMULARY
CN101	HYDROCODONE/ACETAMINOPHEN ORAL	VICODIN	Open Formulary - no restrictions	FORMULARY
HS051	HYDROCORTISONE ORAL	CORTEF	Open Formulary - no restrictions	FORMULARY
DE200	HYDROCORTISONE 1% CREAM (OTC)	CORTEF	Open Formulary - no restrictions	FORMULARY
DE200	HYDROCORTISONE 1% LOTION (OTC)	CORTEF	Open Formulary - no restrictions	FORMULARY
DE200	HYDROCORTISONE 1% OINT	CORTEF	Open Formulary - no restrictions	FORMULARY
RS100	HYDROCORTISONE 100MG/60ML ENEMA	CORTENEMA	Open Formulary - no restrictions	FORMULARY
DE200	HYDROCORTISONE 2.5% CREAM	CORTEF	Open Formulary - no restrictions	FORMULARY
RS100	HYDROCORTISONE ACETATE RTL FOAM	CORTIFOAM	Open Formulary - no restrictions	FORMULARY
HS051	HYDROCORTISONE INJ 100MG/2ML	SOLUCORTEF	Open Formulary - no restrictions	FORMULARY
RS202	HYDROCORTISONE/PRAMOXINE RTL CREAM	PROCTOCREAM	Open Formulary - no restrictions	FORMULARY

RS202	HYDROCORTISONE/PRAMOXINE RTL FOAM	PROCTOFOAM	Open Formulary - no restrictions	FORMULARY
RS202	HYDROCORTISONE/PRAMOXINE RTL OINT	N/A	Open Formulary - no restrictions	FORMULARY
DE101	HYDROGEN PEROXIDE 3% TOP SOLN (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CN101	HYDROMORPHONE 2MG, 4MG TAB	DILAUDID	Open Formulary - no restrictions	FORMULARY
CN101	HYDROMORPHONE INJ 2MG/ML 1ML	DILAUDID	Restrictions per local facility	FORMULARY
DE350	HYDROPHILIC TOP OINT	N/A	Open Formulary - no restrictions	FORMULARY
DE900	HYDROQUINONE 4% TOP CREAM	ELDOPAQUE	Open Formulary - no restrictions	FORMULARY
AP101	HYDROXYCHLOROQUINE SULFATE 200	PLAQUENIL	Open Formulary - no restrictions	FORMULARY
OP500	HYDROXYPROPYLMETHYLCELLULOSE 2.5% 15ML	GONIOSOL; HIGH VISCOSITY ARTIFICIAL TEARS OTC	Open Formulary - no restrictions	FORMULARY
AN300	HYDROXYUREA ORAL	HYDREA	Open Formulary - no restrictions	FORMULARY
AH500	HYDROXYZINE INJ 50MG/ML	VISTARIL	Open Formulary - no restrictions	FORMULARY
AH105	HYDROXYZINE PAMOATE ORAL	VISTARIL	Open Formulary - no restrictions	FORMULARY
AH105	HYDROXYZINE SYRUP	N/A	Open Formulary - no restrictions	FORMULARY
OP500	HYPROMELLOSE/DEXTRAN-70 OPHTH SOLN	OCUCOAT EQUIV	Open Formulary - no restrictions	FORMULARY
MS102	IBUPROFEN 400MG, 600MG, 800MGTAB	MOTRIN	Open Formulary - no restrictions	FORMULARY
MS102	IBUPROFEN ORAL SUSPENSION	N/A	Open Formulary - no restrictions	FORMULARY
CV250	IBUTILIDE INJ	CORVERT	Restricted to Cardiology Service or local equivalent.	FORMULARY
AN200	IDARUBICIN INJ	IDAMYCIN	Restrictions per local facility	FORMULARY
AN100	IFOSFAMIDE INJ	IFEX	Restrictions per local facility	FORMULARY
AN100	IFOSFAMIDE/MESNA INJ	IFEX/MESNEX	Restrictions per local facility	FORMULARY
AN900	IMATINIB MESYLATE ORAL	GLEEVAC	Imatinib mesylate (Gleevec) is formulary, restricted to Hematology/Oncology for patients with chronic myelogenous leukemia (CML), acute lymphoblastic leukemia (ALL), or gastrointestinal stromal tumor (GIST)	FORMULARY
CN601	IMIPRAMINE HCL 25MG, 50MG TAB	TOFRANIL	Open Formulary - no restrictions	FORMULARY
IM900	IMIQUIMOD 5% TOPICAL CREAM	ALDARA	VA National Criteria for the Use of Topical Imiquimod These criteria were based on the best clinical evidence currently available. The recommendations in this document are dynamic, and will be revised as new clinical information becomes available. This guidance is intended to assist practitioners in providing consistent, high-quality, cost-effective drug therapy. These criteria are not intended to interfere with clinical judgment; the	FORMULARY

			clinician must ultimately decide the course of therapy based on individual patient situations. Criteria for Use: All of the following criteria must be met (answered YES) to use imiquimod. 1. The provider documents that, after discussing treatment options with the patient, surgical methods (including cryosurgery) are deemed to be medically less appropriate treatment for the patient's lesions or are refused by the patient, OR that medical therapy is indicated as an adjunct to or instead of surgical methods. 2. Patient follow-up can be reasonably assured. 3. Patient fulfills any one of the criteria in either A, B, or C below. Use caution when prescribing imiquimod in immunocompromised patients. A. Patient is under the care of a dermatologist and meets any of the following conditions: * Actinic Keratosis-must have clinically typical, nonhyperkeratotic, nonhypertrophic lesions AND Patient has had a documented inadequate response after at least one 4-week treatment course of topical 5-fluorouracil 0.5% to 2% (one 3-week course for 5% formulation), OR has a documented intolerance or contraindication to 5-fluorouracil formulations. * Superficial Basal Cell Carcinoma-biopsy-confirmed; located on the trunk (not anogenital skin), neck, extremities (not hands and feet), or head (excluding areas within 1 cm of the eyes, nose, and mouth) Topical 5-fluorouracil 5% is also FDA-approved for sBCC and, used with occlusion, is an alternative to consider in selected patients with small, thin, superficial tumors in whom followup can be reasonably assured. * Intraepithelial neoplasia / Bowen's disease / bowenoid papulosis / squamous cell carcinoma in situ-histologically confirmed AND Patient has had a documented inadequate response after at least 4 weeks of treatment with topical 5-fluorouracil 5% formulations with occlusion OR has a documented intolerance or contraindication to 5-fluorouracil formulations. * Nodular basal cell carcinoma-biopsy-confirmed (excluding areas of the head within 1 cm of the eyes, nose, and mouth) B. Patient is under the care of a dermatologist, gynecologist, urologist, or Women's Health provider and meets the following conditions: * Isolated external genital warts (< 10) on the penile shaft, glans or vulvar areas or isolated perianal warts AND Patient has had a documented inadequate response to topical 0.5% podofilox (at least 4 one-week cycles) or podophyllin (25% or higher strength for at least 4 weekly applications), or trichloroacetic acid	

			(80% or higher strength for at least 4 weekly applications) OR has a documented contraindication or intolerance to any one of these agents. * Extensive or severe external genital or perianal warts; e.g., more than 20 to 30 individual warts or warts involving large areas of skin in areas otherwise difficult to treat with typical destructive modalities such as cryotherapy or podophyllin. C. Patient is under the care of a dermatologist or primary care provider and meets any of the following conditions: * Any type of cutaneous wart located on the face * Nongenital, nonfacial flat warts (verruca plana) in patients who have a documented intolerance, contraindication, or inadequate response to 2 weeks of topical salicylic acid therapy AND either 5 weeks of topical 5-fluorouracil 1% to 5% or 3 weeks of topical tretinoin 0.025% to 0.5%, each alone or as adjunct to other therapy. * Palmar, plantar, or nonfacial common warts in patients who have a documented intolerance, contraindication, or inadequate response to 2 weeks of topical salicylic acid alone or as adjunct to other therapy Exclusions: Patient should not receive imiquimod if any one of the following criteria are met. For any patient: 1. Hypersensitivity to imiquimod or other product components 2. Prevention of recurrence of herpes genitalis (shown to be ineffective) 3. NO beneficial response 12 weeks (for superficial basal cell carcinoma) or 16 weeks (for actinic keratosis and external genital wart) after the start of therapy Recommended Maximal Doses For patients with superficial basal cell carcinoma, the prescribed dose is not more frequent than 5 times per week. Although a 7-times-per-week dosing regimen of imiquimod cream 5% has been shown to be efficacious, it has been shown to be not better than 5 times per week. For patients with external genital warts, the prescribed dose is not more frequent than 3 times per week. Doses more frequent than the recommended 3 times weekly regimen have been shown to increase toxicity but not efficacy. Weigh Risks Versus Benefits Some experts consider imiquimod to be a useful, albeit costly, agent for a number of off-label uses. Other medical therapies or surgical methods can usually be used, but some experts may consider imiquimod to be appropriate as a first-line agent in selected individuals. There are a number of off-label uses and doses that are supported by only small and single (unverified) randomized controlled trials, uncontrolled observational studies, or case reports/series. Consider the	

			appropriateness of use of topical imiquimod on a case-by-case basis. Use caution in patients who have autoimmune and other immune-mediated disorders, as imiquimod is an immune modulator. It is not clear whether imiquimod will be effective or to what extent it will be effective in immunosuppressed patients. In patients with cancers that tend to metastasize, consider that imiquimod may limit locoregional spread but may not prevent lymphogenous / systemic metastasis. Potential off-label uses supported by single randomized controlled trials include * cutaneous leishmaniasis (add-on therapy) * molluscum contagiosum * squamous cell carcinoma in renal transplant recipients (preventive therapy) * external genital warts in HIV-infected adults with CD4 counts > 100 and Karnofsky score > 70 (ineffective in complete clearance of warts but significantly reduced wart area) Conditions for which imiquimod treatment was reported to be beneficial in uncontrolled observational studies or case reports/series include * molluscum contagiosum * lentigo maligna / melanoma in situ * squamous cell carcinoma (preventive therapy). * pyogenic granuloma Off-label doses whose superiority over FDA-recommended doses are currently not supported by appropriately designed randomized controlled trials include: * dosing 3 times per week in actinic keratosis (lack of dose-controlled randomized trials, but safety and efficacy are supported by vehicle-controlled randomized trials). Preliminary results of a double-blind, long-term, observational follow-up study suggest there were numerically lower recurrence rates among patients who had achieved complete clearance in phase III trials evaluating imiquimod dosed 3 times per week than among patients who achieved complete clearance in trials that used the FDA-recommended twice weekly dosing. However, the long-term study was conceived after completion of phase III trials, dosage comparisons were made indirectly without statistical analyses, and results may reflect selection bias. Indirect comparisons of vehicle-corrected complete clearance rates in short-term studies do not support that there is a difference in efficacy between the two doses, although local adverse events may be more common with the higher dosage. As there are RCTs to support using a thrice-weekly dosing regimen, the higher dosing frequency may be reasonable to consider in patients who are at relatively high risk for recurrence (e.g., because of lesion location, number and extent of	

			lesions, skin type, co-morbidities, etc.) or have had recurrence of AK after twice weekly dosing. * cycle therapy in actinic keratosis (lack of randomized trials; preliminary data)-involves application of imiquimod cream 5% once daily 3 days per week for 4 weeks followed by a rest period of 4 weeks, and repeating the 8-week cycle if necessary for any residual lesions up to a maximum of 3 cycles (24 weeks). March 2007 VISN 20 P&T Committee	
CV900	INAMRINONE INJ	INOCOR	Restrictions per local facility	FORMULARY
XA304	INCONTINENCE LINER	N/A	Open Formulary - no restrictions	FORMULARY
XA900	INCONTINENT SHEATH HOLDER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CV701	INDAPAMIDE ORAL	LOZOL	Open Formulary - no restrictions	FORMULARY
AM800	INDINAVIR S04 ORAL	CRIXIVAN	Restricted to ID Service or local equivalent	FORMULARY
DX101	INDOCYANINE GREEN INJ	N/A	Open Formulary - no restrictions	FORMULARY
MS102	INDOMETHACIN ORAL	INDOCIN	Open Formulary - no restrictions	FORMULARY
IM100	INFLUENZA VIRUS VACCINE INJ	N/A	Open Formulary - no restrictions	FORMULARY
AD900	INSECT STING TREATMENT KIT INJ	ANA-KIT	Open Formulary - no restrictions	FORMULARY
HS501	INSULIN ASPART	NOVOLOG	Restricted to patients who meet the following criteria: A. Patient selection: Patient must meet one of the following: 1. Type I diabetic with inadequate response (HgbA1c >8.0) 2. Patient should demonstrate inadequate control with current insulin therapy (a) Type I diabetic with repeated hypoglycemic episodes (b) Type I diabetic who has attempted tight control but failed B. Rapid acting insulin is substituted for regular insulin; because of its rapid onset of action, patients need to inject rapid acting insulin immediately prior to eating. C. Blood glucose should be monitored frequently after switching from regular insulin. D. Dose modifications of concurrent longer-acting insulin preparations may be necessary. August 1998, August 2003 VISN P&T Committee	FORMULARY
HS501	INSULIN DETEMIR INJ	LEVEMIR	Open Formulary - no restrictions	FORMULARY
HS501	INSULIN GLARGINE INJ	LANTUS	Open Formulary - no restrictions	FORMULARY
HS501	INSULIN HUMAN 50/50 (NPH/REG) INJ (OTC)	NOVOLIN	Open Formulary - no restrictions	FORMULARY
HS501	INSULIN HUMAN 70/30 (NPH/REG) INJ (OTC)	NOVOLIN	Open Formulary - no restrictions	FORMULARY
HS501	INSULIN NPH HUMAN 100 U/ML INJ (OTC)	NOVOLIN	Open Formulary - no restrictions	FORMULARY

HS501	INSULIN PEN DEVICES	N/A	Insulin pen devices are formulary, restricted to patients with diabetes who (1) demonstrate an inability to draw insulin from a multidose vial into a syringe (especially for extremely-low doses). Patient abilities must be evaluated by health care professionals knowledgeable in insulin administration, and the evaluation documented in the medical record. OR (2) use short acting analogs in intensive multi-dose therapy for veterans based upon lifestyle. February 2008, VISN 20 P&T Committee	FORMULARY
HS501	INSULIN REG HUMAN 100 U/ML INJ (OTC)	NOVOLIN	Open Formulary - no restrictions	FORMULARY
XA854	INSULIN SYRINGE	N/A	Open Formulary - no restrictions	FORMULARY
XA854	INSULIN SYRINGE LOW DOSE	N/A	Open Formulary - no restrictions	FORMULARY
IM700	INTERFERON ALFA-2A INJ	ROFERON	Restrictions for National Formulary drugs interferon alpha-2a, 2b and 3n are as follows: (1) restricted to the treatment of approved indications, with interferon alpha-2b considered first-line, and alpha-2a and alpha-3n second-line, (2) restricted to Infectious Disease, Oncology, and Gastroenterology Services, or local facility equivalents, and (3) approval for use in non-labeled indications be regulated by the Chief of Medical Service for each facility	FORMULARY
IM700	INTERFERON ALFA-2B INJ	INTRON	Restrictions for National Formulary drugs interferon alpha-2a, 2b and 3n are as follows: (1) restricted to the treatment of approved indications, with interferon alpha-2b considered first-line, and alpha-2a and alpha-3n second-line, (2) restricted to Infectious Disease, Oncology, and Gastroenterology Services, or local facility equivalents, and (3) approval for use in non-labeled indications be regulated by the Chief of Medical Service for each facility	FORMULARY
IM700	INTERFERON ALFA-3N INJ	ALFERON	Restrictions for National Formulary drugs interferon alpha-2a, 2b and 3n are as follows: (1) restricted to the treatment of approved indications, with interferon alpha-2b considered first-line, and alpha-2a and alpha-3n second-line, (2) restricted to Infectious Disease, Oncology, and Gastroenterology Services, or local facility equivalents, and (3) approval for use in non-labeled indications be regulated by the Chief of Medical Service for each facility	FORMULARY
IM700	INTERFERON ALFACON-1	INFERGEN	FORMULARY, CFU	FORMULARY
IM900	INTERFERON BETA 1B	EXTAVIA	Formulary	FORMULARY

IM900	INTERFERON BETA-1A INJ	AVONEX, REBIF (BOTH)	Interferon beta-1a (Avonex and Rebif), Interferon beta-1b (Betaseron), and Glatiramer (Copaxone) are all formulary with the following restrictions: Restricted to Neurology Services, Physical Medicine and Rehabilitation Services, Multiple Sclerosis Clinic or local facility equivalent. Initiation and Treatment Criteria as follows: Initiation Criteria: a. Initiation of therapy is advised as soon as possible following a definite diagnosis of MS and determination of a relapsing course. b. Patients' access to medication should not be limited by the frequency of relapses, age, or level of disability. Treatment Criteria: a. Patients should not be treated with both glatiramer and a beta interferon concurrently. b. The effectiveness and continued treatment will be determined by the treating prescriber. Patients will be re-evaluated every two years to determine continued effectiveness of treatment February 2000, May 2003	FORMULARY
IM900	INTERFERON BETA-1B INJ	BETASERON	Interferon beta-1a (Avonex and Rebif), Interferon beta-1b (Betaseron), and Glatiramer (Copaxone) are all formulary with the following restrictions: Restricted to Neurology Services, Physical Medicine and Rehabilitation Services, Multiple Sclerosis Clinic or local facility equivalent. Initiation and Treatment Criteria as follows: Initiation Criteria: a. Initiation of therapy is advised as soon as possible following a definite diagnosis of MS and determination of a relapsing course. b. Patients' access to medication should not be limited by the frequency of relapses, age, or level of disability. Treatment Criteria: a. Patients should not be treated with both glatiramer and a beta interferon concurrently. b. The effectiveness and continued treatment will be determined by the treating prescriber. Patients will be re-evaluated every two years to determine continued effectiveness of treatment February 2000, May 2003	FORMULARY
IM700	INTERFERON GAMMA-1B INJ	ACTIMMUNE	Restricted to ID Service or local equivalent	FORMULARY
DX101	IOPROMIDE 300MG/ML INJ	ULTRAVIST	Open Formulary - no restrictions	FORMULARY
DX101	IOPROMIDE 370MGI/ML INJ	ULTRAVIST 370	Open Formulary - no restrictions	FORMULARY
DX102	IOTHALAMATE MEGLUMINE 60% INJ	CONRAY	Open Formulary - no restrictions	FORMULARY
GA600	IPECAC SYRUP 30ML	N/A	Open Formulary - no restrictions	FORMULARY

RE105	IPRATROPIUM BROMIDE INHL SOLN	ATROVENT	Restricted to patients who have physical, visual, mental or cognitive impairments that prevent efficacious use of a metered dose inhaler (MDI) after adequate instruction, including the use of a spacer.	FORMULARY
RE105	IPRATROPIUM BROMIDE NASAL SPRAY	ATROVENT	Restricted to patients who fail first generation antihistamines or nasal steroids	FORMULARY
RE105	IPRATROPIUM BROMIDE ORAL INHL 18MCG 200D MDI	ATROVENT	Open Formulary - no restrictions	FORMULARY
AN900	IRINOTECAN INJ	CAMPTOSAR	Restrictions per local facility	FORMULARY
TN401	IRON DEXTRAN COMPLEX (LOW MOLECULAR WEIGHT)	INFED	Open Formulary - no restrictions	FORMULARY
TN410O	IRON SUCROSE INJECTION SOLUTION	VENOFER	Open Formulary - no restrictions	FORMULARY
XA900	IRRIGATING SYRINGE CATHETER TIP (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	IRRIGATING SYRINGE,BULB CATHETER TIP 60ML	N/A	Open Formulary - no restrictions	FORMULARY
XA607	IRRIGATION SLEEVE,SUR-FIT C#0242-52 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA607	IRRIGATION SLEEVE,SUR-FIT C#0242-53 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA607	IRRIGATION SLEEVE,SUR-FIT C#0242-54 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA607	IRRIGATOR DRAIN (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA607	IRRIGATOR,VISI-FLOW (OTC)	VISI-FLOW	Open Formulary - no restrictions	FORMULARY
CN201	ISOFLURANE 100ML	FORANE	Open Formulary - no restrictions	FORMULARY
AM500	ISONIAZID 300MG TAB	LANIAZID	Open Formulary - no restrictions	FORMULARY
AM500	ISONIAZID INJ	NYDRAZID	Open Formulary - no restrictions	FORMULARY
AM500	ISONIAZID/RIFAMPIN ORAL	RIFAMATE	Open Formulary - no restrictions	FORMULARY
AU100	ISOPROTERENOL INJ	ISUPREL	Open Formulary - no restrictions	FORMULARY
CV250	ISOSORBIDE DINITRATE 5MG, 10MG, 20MG TAB, RR	ISORDIL	Open Formulary - no restrictions	FORMULARY
CV250	ISOSORBIDE DINITRATE TAB, SA	DILATRATE	Isosorbide dinitrate SA is second-line long acting isosorbide, restricted to patients who cannot be treated with isosorbide mononitrate SA. November 2007 VISN 20 P&T Committee	FORMULARY
CV250	ISOSORBIDE MONONITRATE TAB, SA	IMDUR	Open Formulary - no restrictions	FORMULARY
DE751	ISOTRETINOIN ORAL	ACCUTANE	VA National Criteria for Use of Isotretinoin Inclusion Criteria The response to ALL items below must be YES to use orally administered isotretinoin. - Provider authorizing the initiation of therapy is a dermatologist	FORMULARY

			and is registered in iPledge. Subsequent prescriptions may be renewed by dermatologists or other locally authorized clinicians (including nurse practitioners or physician assistants). Approved clinicians should be under the supervision of or, in a co-managed care situation, working with a dermatologist, and appropriate patient monitoring must be followed. Prescribers, Delegated Prescribers, and Designees, as defined in the iPledge program, must be registered in iPledge (www.iPLEDGEprogram.com). Patient meets either ONE of the following criteria: 1. Severe nodulocystic acne vulgaris (many inflammatory nodules >5 mm in diameter) AND has documented inadequate response, intolerance, or contraindication to at least 4 weeks of prior combined therapy with 2 anti-acne topical agents of different classes (e.g., benzoyl peroxide, retinoid, antibiotic) AND 1 non-retinoid systemic therapy 2. Moderate to severe acne vulgaris (erythematous papules, pustules, nodules limited mostly to face, evidence of scarring, or acne lesions with potential for scarring) AND has documented inadequate response, intolerance, frequent relapses, or contraindication to prior treatment with topical benzoyl peroxide and at least 2 of each of the following types of formulary and nonformulary agents (at least 6-week trial for each agent alone or the combination of >2 agents): topical antibiotics, topical retinoids, systemic antibiotics, antiandrogen / hormonal therapies (females only). Examples of Formulary agents: Topical- benzoyl peroxide + erythromycin, erythromycin, tretinoin. Oral- clindamycin, doxycycline, erythromycin, minocycline, tetracycline, various oral contraceptives. Examples of nonformulary agents: Topical - adapalene, dapsone, tazarotene Oral -oxytetracycline Patient meets all requirements of iPLEDGE (regardless of condition to be treated with isotretinoin), summarized in part below: - Patient agrees to avoid donating blood during the period of teratogenic risk (during therapy and for 1 month after discontinuation of isotretinoin) - If female, patient has been counseled and agrees to avoid pregnancy by using two effective forms of contraception simultaneously and continuously for one month before, during, and one month after isotretinoin therapy, unless patient is committed to continuous abstinence from heterosexual contact, has had a hysterectomy or bilateral oophorectomy, or is medically confirmed to be postmenopausal - Patient has signed the isotretinoin Patient Information/Informed Consent (for All Patients)	

			and, if patient is a female of childbearing potential, has signed an isotretinoin Patient Information / Informed Consent About Birth Defects (for female patients who can get pregnant) (see http://www.rocheusa.com/products/accutane/pi.pdf , pp. 31-39) - If patient is a female of childbearing potential, she must have two negative urine or serum pregnancy tests with sensitivities of at least 25 mIU / ml before starting therapy: the first, a screening test, done by the prescriber when the decision is made to pursue qualification of the patient for isotretinoin therapy; and the second, a confirmation test, done at least 19 days after the screening test in a CLIA-certified laboratory and after the patient has used two contraceptive methods simultaneously for at least 1 month; the tests must be timed according to the regularity of the patient's menstrual cycles (check Product Information for details); patient must also have negative monthly pregnancy tests during therapy - Provider and patient are registered and activated in the pregnancy risk management program, iPLEDGE - Prescriber has questioned patient or patient's family about prior psychiatric disorders, and has determined that the potential benefits of isotretinoin outweigh its potential risks, which include depression, mood disorder, psychosis, or aggression) - Patient has been counseled on the possible association between isotretinoin and depression, psychosis, suicidality, psychiatric disorders, and aggression Exclusion Criteria If the patient meets any of the criteria below, then the patient should NOT receive isotretinoin: - Patient has mild acne vulgaris (comedones with no or minimal inflammatory lesions) - Patient is pregnant, planning pregnancy, or is nursing - Patient has contraindication to isotretinoin (i.e., hypersensitivity to isotretinoin or its components, such as parabens) - Patient is taking tetracyclines (risk of pseudotumor cerebri), St. John's Wort (interaction with hormonal contraceptives), supplements containing vitamin A (risk of hypervitaminosis A) - Use of isotretinoin for any of the following conditions: cervical cancer, cancer chemoprevention, condylomata acuminata (venereal warts in men), cutaneous T-cell lymphoma-Sizary syndrome, myelodysplastic syndrome, ovarian cancer, renal cell carcinoma Discontinuation Criteria If the patient meets any of the criteria below, then isotretinoin should be discontinued: - Patient on isotretinoin for acne shows NO evidence of beneficial clinical effects within 4 months of starting	

			therapy. - Patient is female and has unprotected heterosexual intercourse within one month before, during, or one month after isotretinoin therapy. If any of the following occur, then isotretinoin should be discontinued and the patient referred for further evaluation: - The patient becomes pregnant during isotretinoin therapy Pregnancy must be reported to FDA MedWatch 1-800-FDA-1088 AND iPLEDGE pregnancy registry (1-866-495-0654 or www.iPLEDGEprogram.com) - Patient develops depression, mood disorder, psychosis, or aggression The patient develops any of the following adverse effects: - Pseudotumor cerebri (papilledema, headache, nausea, vomiting, and visual disturbances) - Uncontrolled hypertriglyceridemia or pancreatitis - Unexplained hearing loss or tinnitus - Persistent increase in liver enzymes or hepatitis - Inflammatory bowel disease (abdominal pain, severe diarrhea, rectal bleeding) - Visual difficulties Dispensing Limits Wholesalers, providers, pharmacies, and patients must be registered, activated, and meet ALL requirements in iPLEDGE. To prescribe and dispense isotretinoin, the prescriber and pharmacy must access the iPLEDGE system via the internet (www.ipledgeprogram.com) or telephone (1-866-495-0654). Patients must have the prescription for isotretinoin filled within 7 days of the clinic visit and should receive no more than a 30-day supply of isotretinoin without automatic refills Monitoring - Check urine or serum pregnancy test every month during isotretinoin therapy, at completion of therapy, and one month after discontinuation of therapy, as required by iPLEDGE. Pregnancy tests should have a sensitivity of at least 25 mIU / ml and must be CLIA-certified (Clinical Laboratory Improvement Amendment). Authorization to dispense isotretinoin will not be granted by iPLEDGE without a monthly negative pregnancy test. - Counsel patient monthly to reinforce avoidance of pregnancy and the warning not to share isotretinoin with others, as required by iPLEDGE - Pharmacists must provide patient with an isotretinoin Medication Guide each time drug is dispensed, as required by law - Evaluate patient for possible depression, mood disturbance, psychosis, or aggression at each visit - Check blood lipid concentrations before starting therapy and at weekly or biweekly intervals until lipid response is established (usually within 4 weeks); monitor more frequently or for a longer period in patients at risk (e.g., those with

			diabetes mellitus, hyperlipidemia, family history of hyperlipidemia, obesity, increased alcohol use, or pancreatitis) - Check liver enzymes before starting therapy and at weekly or biweekly intervals until response is established. June 16th 2006 VISN 20 P&T Committee	
AM700	ITRACONAZOLE ORAL	SPORANOX	Restricted to ID Service or local equivalent	FORMULARY
XA802	IV SET PRIMARY (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA809	IV SET SECONDARY (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
AP200	IVERMECTIN ORAL	STROMECTOL	Open Formulary - no restrictions	FORMULARY
TN408	K PHOSPHATE/NA BIPHOSPHATE/NA PHOSPHATE TAB	K-PHOS NEUTRAL	Open Formulary - no restrictions	FORMULARY
XA199	KALTOSTAT CA/NA ALGINATE WOUND PACKING (OTC)	KALTOSTAT	Open Formulary - no restrictions	FORMULARY
XA199	KALTOSTAT DRESSING (OTC)	KALTOSTAT	Open Formulary - no restrictions	FORMULARY
XA199	KALTOSTAT FORTEX CA/NA ALGINATE DRESSING (OTC)	KALTOSTAT	Open Formulary - no restrictions	FORMULARY
AM300	KANAMYCIN INJ	KANTREX	Restrictions per local facility	FORMULARY
XA109	KERLIX (OTC)	KERLIX	Open Formulary - no restrictions	FORMULARY
XA109	KERLIX 4.5IN NONSTERILE GAUZE (OTC)	KERLIX	Open Formulary - no restrictions	FORMULARY
XA109	KERLIX 4.5IN STERILE BANDAGE,GAUZE	N/A	Open Formulary - no restrictions	FORMULARY
XA101	KERLIX SUPER SPONGE MEDIUM STERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA604	KERODEX TOP CREAM (OTC)	KERODEX	Open Formulary - no restrictions	FORMULARY
CN203	KETAMINE INJ	KETALAR	Restrictions per local facility	FORMULARY
DE102	KETOCONAZOLE 2% CREAM	NIZORAL	Restricted to Dermatology or local equivalent	FORMULARY
DE102	KETOCONAZOLE 2% SHAMPOO	NIZORAL	Open Formulary - no restrictions	FORMULARY
AM700	KETOCONAZOLE ORAL	NIZORAL	Open Formulary - no restrictions	FORMULARY
CN103	KETOROLAC TROMETH INJ	TORADOL	Restrictions per local facility	FORMULARY
OP300	KETOROLAC TROMETHAMINE OPH SOLN	ACULAR	Open Formulary - no restrictions	FORMULARY
OP900	KETOTIFEN OPHTH SOLN	ZADITOR	Open Formulary - no restrictions	FORMULARY
XA109	KLING ELASTIC GAUZE (OTC)	KLING	Open Formulary - no restrictions	FORMULARY
CV100	LABETALOL HCL INJ	TRANDATE	Restrictions per local facility	FORMULARY
GA500	LACTASE TAB (OTC)	N/A	Open Formulary - no restrictions	FORMULARY

TN102	LACTATED RINGERS INJ 1000ML	N/A	Open Formulary - no restrictions	FORMULARY
IR100	LACTATED RINGERS IRRG SOLN	N/A	Open Formulary - no restrictions	FORMULARY
DE500	LACTIC ACID 16.7%/SAL AC 16.7%/COLLODION (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE350	LACTIC ACID 5% LOTION (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE900	LACTIC ACID 5% TOP CREAM (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
GA400	LACTOBACILLUS CHEW TAB, ORAL CAPSULE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
GA202	LACTULOSE 10GM/15ML SYRUP	ENULOSE	Open Formulary - no restrictions	FORMULARY
XA900	LAMBS WOOL (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
AM800	LAMIVUDINE 100MG, 150MG TAB	EPIVIR AND EPIVIR-HBV	Lamivudine 100mg tablets are restricted to GI/Hepatology, ID or local facility equivalent. Lamivudine 150mg tablets are restricted to HIV prescribers or local facility equivalent. September, 1997; January 2007	FORMULARY
AM800	LAMIVUDINE 150MG/ZIDOVUDINE 300MG TAB	COMBIVIR	Restricted to HIV prescribers	FORMULARY
AM800	LAMIVUDINE ORAL SOLN	EPIVIR	Restricted to patients unable to take oral tablets.	FORMULARY
CN400	LAMOTRIGINE ORAL	LAMICTAL	Lamotrigine is formulary, restricted to neurology service, epilepsy clinic, or local facility equivalent when used as an anticonvulsant. Restricted to mental health/psychiatry for the treatment of bipolar depression. Bipolar depression ??? can be the first line treatment Target dose of lamotrigine is 200mg/day or as tolerated Unipolar depression ??? remains Nonformulary; requires completion of an NDR. Criteria: 1. Must fail at least two antidepressants, including one SSRI and Venlafaxine. 2. Failure is defined as lack of treatment response after 12 weeks of therapy	FORMULARY
XA900	LANCET	N/A	Open Formulary - no restrictions	FORMULARY
XA900	LANCET HOLDER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE350	LANOLIN HYDROUS OINT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
TN490	LANTHANUM CARBONATE	FOSRENAL	FORMULARY, CFU	FORMULARY
TN490	LANTHANUM CARBONATE ORAL TAB	FOSRENOL	Criteria for Use Checklist Non-Calcium, Non-Aluminum Phosphate Binders (Lanthanum Carbonate, Sevelamer Carbonate, Sevelamer Hydrochloride) for the Management of Hyperphosphatemia in Chronic Kidney Disease VHA Pharmacy Benefits Management Services and Medical Advisory Panel INCLUSION CRITERIA FOR A NON-CALCIUM. NON-ALUMINUM	FORMULARY

			PHOSHPHATE BINDER (must fulfill the following to be eligible) The non-calcium, non-aluminum phosphate binders (lanthanum carbonate, sevelamer carbonate, sevelamer hydrochloride) are restricted to Nephrology Service(a) and are to be used for the management of patients with chronic kidney disease (CKD) and hyperphosphatemia according to the criteria below: 0 Diagnosis of Stage 5 CKD (defined as kidney failure with GFR < 15 mL/min/1.73m2 or dialysis) and receiving kidney replacement therapy (i.e., hemodialysis or peritoneal dialysis) OR 0 Stage 3 to 5 CKD (refer to GFR range below) not receiving kidney replacement therapy Stage 3 CKD Stage 4 CKD Stage 5 CKD 30 to 59 mL/min/1.73m2 15 to 29 mL/min/1.73m2 < 15 mL/min/1.73m2 AND 0 Documented hyperphosphatemia AND one or more of the following: 0 Serum phosphorus > 6.0 mg/dl (b) despite dietary restriction of phosphate to < 1gm/d AND adherence to maximally tolerated dose of calcium based phosphate binders (c) 0 Total serum calcium (corrected for serum albumin)(d) > 10.2 mg/dl (or maximum per lab/facility) on conventional treatment with calcium based phosphate binding therapy (c) and despite discontinuation of vitamin D preparations for at least 1 month 0 Intact plasma parathyroid hormone (PTH) level < 2 times the upper limit of normal (ULN) for PTH assay (K/DOQI Guideline recommendations < 150 pg/ml based on assay with ULN 75 pg/ml) with normal or elevated serum calcium (corrected for serum albumin;(d) elevated > 10.2 mg/dl or maximum per lab/facility) associated with adynamic bone disease 0 Calcium x phosphorus product > 55 mg2/dl2 despite dietary restriction of phosphate to < 1 gm/d AND calcium based phosphate binders (c) notes - a) Restricted to Nephrology for the initial prescription; if deemed appropriate, local P&T Committees may approve selected providers to renew prescriptions b) Kalantar-Zadeh K, et al. Survival predictability of time-varying indicators of bone disease in maintenance hemodialysis patients. Kidney Int 2006;70:771-80. Block GA, et al. Mineral metabolism, mortality, and morbidity in maintenance hemodialysis. J Am Soc Nephrol 2004;15:2208-18. Ganesh SK, et al. Association of elevated serum PO4, Ca, Ca X PO4 product, and parathyroid hormone with cardiac mortality risk in chronic hemodialysis patients. J Am Soc Nephrol 2001;12:2131-8. Block GA, et al. Association of serum phosphorus and calcium x phosphorus product with	

			mortality risk in chronic hemodialysis patients: a national study. Am J Kidney Dis 1998;31:607-17. c) An aluminum containing phosphate binder should NOT be used for long-term management of hyperphosphatemia due to potential toxicity. K/DOQI Guideline recommendations are to limit elemental calcium intake from phosphate binders to < 1500 mg/d, with the total daily intake (including dietary calcium) of elemental calcium not to exceed 2,000 mg. In addition, use of 2.5mEq/L calcium dialysate or lower, if indicated should be part of therapy to reduce hypercalcemia. d) Calculation for corrected total serum calcium=total calcium + 0.8 (4 - serum albumin) [4 gm/dl (normal serum albumin) - most recent serum albumin] Ex. Calcium 9.9 mg/dl; albumin 3.2 gm/dl [4 - 3.2] = 0.8; 0.8 X 0.8 = 0.64 9.9 + 0.64 = 10.54 (10.5 mg/dl is the corrected serum calcium) EXCLUSION CRITERIA (if ONE is checked, patient is not eligible) Lanthanum carbonate 0 Hypophosphatemia Sevelamer carbonate or sevelamer hydrochloride 0 Hypophosphatemia 0 Bowel obstruction DOSING RECOMMENDATIONS 0 Lanthanum carbonate: initial recommended dose is 250 mg to 500 mg three times daily; doses may be increased by 750 mg every 2 to 3 weeks until serum phosphorus goal is achieved. Usual maintenance dose (to achieve phosphorus < 6.0 mg/dl in clinical trials) is 500 mg to 1000 mg three times daily (maximum dose studied 3750 mg daily in divided doses); doses should be administered with meals. The manufacturer recommends that medications that interact with antacids should not be administered within 2 hours of lanthanum carbonate. 0 Sevelamer carbonate or sevelamer hydrochloride: initial recommended dose is 800 mg to 1600 mg three times daily; doses may be increased by 800 mg three times daily every 2 weeks, based on response. Usual maintenance dose (to achieve phosphorus < 5.0 mg/dl in clinical trials) is 2400 mg three times daily (maximum dose studied are 14 gm daily for sevelamer carbonate and 13 gm daily for sevelamer hydrochloride in divided doses); doses should be administered with meals. Patients receiving medications where a reduction in bioavailability may result in a significant clinical impact on the safety or efficacy of the medication should be instructed to take the medication at least 1 hour before or 3 hours after sevelamer carbonate or sevelamer hydrochloride, or the provider should consider monitoring blood levels of the medication. MONITORING 0 Lanthanum carbonate:	

			serum phosphorus levels should be monitored as needed during titration and regularly once on maintenance dose 0 Sevelamer carbonate and sevelamer hydrochloride: phosphorus, bicarbonate, chloride levels should be monitored. Rare cases of increased TSH reported with concomitant levothyroxine; monitor TSH in patients taking sevelamer carbonate or sevelamer hydrochloride and levothyroxine 0 If the patient does not respond adequately despite prescribing the maximum studied doses, reevaluate adherence to the medication regimen and to dietary restrictions. Consider referral to dietitian and reinforce importance of medication adherence RECOMMENDATIONS FOR DISCONTINUATION OR DECREASE IN DOSE 0 Patient does not experience an improvement in serum phosphorus 0 Patient experiences a significant drug related adverse event VISN 20 P&T Committee January 2009, June 2010	
XA599	LEG BAG STRAP ELASTIC	N/A	Open Formulary - no restrictions	FORMULARY

IM900	LENALIDOMIDE ORAL CAPSULE	REVLIMID	Lenalidomide Criteria for Use: Restricted to VA Hematologists and Oncologists VISN 20 P&T Committee July 2006, May 2010 The VHA Clinical Guidance for the Initial management of Adults with Multiple Myeloma was completed in August 2009 by the PBM, MAP, and VACO Oncology Service Consultants. It provides a treatment algorithm for patients with symptomatic Multiple Myeloma (MM). Multiple myeloma is part of a spectrum of diseases that involves the neoplastic proliferation of a monoclonal plasma cell clone that produces immunoglobulins. Clinical manifestations, including anemia, bone pain, pathologic fractures, infections, hypercalcemia, renal failure, and coagulopathy are the result of tumor involvement in the bone marrow, the effect of myeloma protein on various end organs, cytokine production by tumor cells or by the bone marrow microenvironment, and deficiencies in humoral and cellular immunity. Patients with smoldering (asymptomatic) myeloma do not require immediate therapy, as therapy provides no clear benefit in this population. There is no standard initial therapy for patients who are not transplant candidates. The regimens with the highest level of evidence to date are the triplet regimens of melphalan plus prednisone and either thalidomide or bortezomib. The addition of thalidomide or bortezomib to melphalan plus prednisone is associated with additional toxicity. Preliminary reports of two and three year survival data with lenalidomide plus dexamethasone have consistently shown good results; while the data are encouraging, there is a need for further follow-up published in peer-reviewed journals. Melphalan and prednisone alone may be used in patients who do not tolerate the novel agents, but response rates to these are lower than with triplet therapies or lenalidomide plus dexamethasone. Upon disease progression, patients should be offered one of the three newer agents which have been shown to benefit overall survival. Initial treatment is based on patients??? candidacy for transplant and other pre-existing conditions. Oct 2009 VISN 20 P&T Committee	FORMULARY

BL100	LEPIRUDIN INJ,PWDR	REFLUDAN	Lepirudin (Refludan) is formulary, restricted to patients with HIT who require anticoagulation. Danaparoid (Orgaran) and argatroban (Acova) are non-formulary. Sept 2006 VISN 20 P&T Any of these agents can be ordered on a non-formulary basis with appropriate justification. The specific agent to use should be determined by the prescriber based on the individual patient. July 2001	FORMULARY
AN900	LETROZOLE	FEMARA	Restricted to Oncology Service or local equivalent	FORMULARY
VT102	LEUCOVORIN CALCIUM INJ	WELLCOVORIN	Open Formulary - no restrictions	FORMULARY
VT102	LEUCOVORIN CALCIUM ORAL	WELLCOVORIN	Open Formulary - no restrictions	FORMULARY
CN400	LEVETIRACETAM INJ	KEPPRA	Open Formulary - no restrictions	FORMULARY
CN400	LEVETIRACETAM ORAL	KEPPRA	National VA Criteria for Use: Levetiracetam (Keppra) Indication for therapy Patient with one of the following conditions: 1. Patient diagnosed with localization-related epilepsy (producing simple or complex partial seizures with or without secondary generalization) AND ONE OF THE FOLLOWING: Incomplete seizure control requiring adjunctive therapy OR Incomplete seizure control intolerant of first-line antiepileptic drugs (phenytoin, carbamazepine, divalproex sodium) OR Concurrent therapy with a drug that is a CYP450 substrate, inducer or inhibitor and has a narrow therapeutic range OR Patient treated off-label as monotherapy (VISN 20 criteria clarification) Dosing Levetiracetam is available as 250 mg, 500 mg, and 750 mg tablets and 100mg/ml oral solution. Levetiracetam may be administered without regards to food. Initiate levetiracetam at 250 mg BID. After 2 weeks, increase to 500 mg BID. If needed, additional dosing increments of 500-1,000 mg/day every 2 weeks can be implemented, to a maximum recommended daily dose of 3,000 mg or to maximum clinically tolerated dose. Adjust dose according to renal function, as follows: Creatinine Clearance (ml/min) Dose (mg) Interval (hours) >80 500-1,500 12 50-80 500-1,000 12 30-49 250-750 12	FORMULARY
OP101	LEVOBUNOLOL OPHTH SOLN	BETAGAN	Open Formulary - no restrictions	FORMULARY
AM900	LEVOFLOXACIN INJ	LEVAQUIN	VA National Fluoroquinolone Criteria for Use Patient Selection: Please note that this document discusses the most common indications for fluoroquinolone use. It is not intended to be a comprehensive list of all appropriate uses of fluoroquinolones. Urinary tract infections: Due to antimicrobial resistance, in many medical centers fluoroquinolones are the antimicrobial	FORMULARY

			of choice for empiric treatment of urinary tract infections. For this indication, based on safety, efficacy and price ciprofloxacin is the fluoroquinolone of choice. Community-acquired pneumonia: Hospitalized patients: First line therapy is generally with the combined use of a macrolide and a beta-lactam agent active against penicillin-resistant Streptococcus pneumoniae (e.g., cefotaxime or ceftriaxone). Fluoroquinolones should generally be considered second line agents for treatment of beta-lactam allergic patients. Outpatients: Use of fluoroquinolones requires radiological evidence of pneumonia and should be consistent with guidelines. Other upper and lower respiratory tract infections: Fluoroquinolones are generally second or third line agents based on the likely or proven susceptibility of known or probable infectious agents. Safety concerns with fluoroquinolone therapy involve the use of these agents in specific populations. O Patients with a history of long QT syndrome, hypokalemia or who are receiving Class Ia or class III antiarrhythmic agents (quinidine, disopyramide, procainamide, sotalol, amiodarone, dofetilide, ibutilide) are predisposed to development of Torsades de Pointes or other cardiac arrhythmias. These arrhythmias have been reported with levofloxacin, gatifloxacin and moxifloxacin. These fluoroquinolones should be avoided in this patient population. O Disturbances of blood glucose, including symptomatic hypoglycemia and hyperglycemia, have been reported with all fluoroquinolones. The risk of dysglycemia is greatest in diabetic patients. However, hypoglycemia and particularly hyperglycemia have occurred in patients without a history of diabetes. Criteria for use of Levofloxacin - both IV and oral If the answer to either Indication for therapy or Identification of risk factors is yes the patient is eligible for levofloxacin therapy Indication for therapy Ventilator dependent pneumonia Y/N Healthcare associated pneumonia Y/N Identification of risk factors Patient at risk for P. aeruginosa; bronchectisis, cystic fibrosis, or previous antibiotic therapy within the past month? Y/N Patient shows no response to current antibiotic therapy? Y/N Levofloxacin dosage Healthcare associated/ventilator dependent pneumonia Normal renal function 750 mg IV daily* Impaired renal function Initial subsequent dosing Ccr 20 to 49 mL/min 750 mg 750 mg every 48 h Ccr 10 to 19 mL/min 750 mg 500 mg every 48 h Hemodialysis 750 mg 500 mg every 48 h CAPD 750 mg 500 mg every 48 h IV - intravenous.	

			PO - orally * - patients may be transitioned to oral levofloxacin therapy when appropriate, either after receiving IV levofloxacin or other appropriate IV therapy. Local consensus protocols should be consulted for specific antibiotic choice(s) and for relevant approval processes in these circumstances. November 2006 VISN 20 P&T Committee	
HS200	LEVONORGESTREL	PLAN B	FORMULARY	FORMULARY
HS200	LEVONORGESTREL 0.75MG TAB	PLAN B	Open Formulary - no restrictions	FORMULARY
HS851	LEVOTHYROXINE INJ 0.5MG	SYNTHROID	Open Formulary - no restrictions	FORMULARY
HS851	LEVOTHYROXINE NA (SYNTHROID) 0.025MG TAB	SYNTHROID	Open Formulary - no restrictions	FORMULARY
HS851	LEVOTHYROXINE NA (SYNTHROID) 0.050MG TAB	SYNTHROID	Open Formulary - no restrictions	FORMULARY
HS851	LEVOTHYROXINE NA (SYNTHROID) 0.088MG TAB	SYNTHROID	Open Formulary - no restrictions	FORMULARY
HS851	LEVOTHYROXINE NA (SYNTHROID) 0.100MG TAB	SYNTHROID	Open Formulary - no restrictions	FORMULARY
HS851	LEVOTHYROXINE NA (SYNTHROID) 0.125MG TAB	SYNTHROID	Open Formulary - no restrictions	FORMULARY
HS851	LEVOTHYROXINE NA (SYNTHROID) 0.15MG TAB	SYNTHROID	Open Formulary - no restrictions	FORMULARY
HS851	LEVOTHYROXINE NA (SYNTHROID) 0.2MG TAB	SYNTHROID	Open Formulary - no restrictions	FORMULARY
DE700	LIDOCAINE 2.5%/PRILOCAINE 2.5% CREAM	EMLA	Open Formulary - no restrictions	FORMULARY
DE700	LIDOCAINE HCL 2% TOP JELLY	XYLOCAINE	Open Formulary - no restrictions	FORMULARY
DE700	LIDOCAINE HCL 4% TOP SOLN	XYLOCAINE	Open Formulary - no restrictions	FORMULARY
DE700	LIDOCAINE HCL 5% TOP OINT	XYLOCAINE	Open Formulary - no restrictions	FORMULARY
GU900	LIDOCAINE HCL URH TOP SOLN	XYLOCAINE	Open Formulary - no restrictions	FORMULARY
CN204	LIDOCAINE INJ 1%	XYLOCAINE	Open Formulary - no restrictions	FORMULARY
CN204	LIDOCAINE INJ 2% 20ML MDV	XYLOCAINE	Open Formulary - no restrictions	FORMULARY
CN204	LIDOCAINE INJ 2% 20ML W/EPINEP	XYLOCAINE	Open Formulary - no restrictions	FORMULARY
CV300	LIDOCAINE INJ 2GM/D5W 500ML PREMIXED	XYLOCAINE	Open Formulary - no restrictions	FORMULARY
CN204	LIDOCAINE INJ 5%/GLUCOSE 7.5%	XYLOCAINE	Open Formulary - no restrictions	FORMULARY
NT300	LIDOCAINE VISCOUS 2%	XYLOCAINE	Open Formulary - no restrictions	FORMULARY

AM900	LINEZOLID INJ	ZYVOX	Recommendation of Use for Linezolid (Zyvox) JUNE 2009 Pharmacy Benefits Management Services and the Medical Advisory Panel FDA APPROVED INDICATION(S) FOR USE - Community-acquired pneumonia caused by Streptococcus pneumoniae including patients with bacteremia and Staphylococcus aureus - Complicated skin and skin structure infections including diabetic foot infections without concurrent osteomyelitis caused by S. aureus, S. pyogenes, or S. agalactiae - Nosocomial pneumonia caused by S. aureus or S. pneumoniae - Uncomplicated skin and skin structure caused by S. aureus or S. pyogenes - Vancomycin-resistant Enterococcus faecium infections including concurrent bacteremia EXCLUSION CRITERIA (If one is selected, patient is NOT eligible) 0 Clinical evaluation of patient with positive microbiology culture(s) is consistent with colonization (not active infection). 0 Known resistance to linezolid. 0 Therapy for catheter-related bloodstream or catheter-site infections if the infection is not known to be due to only Gram-positive organisms(s). Contraindications: 0 Known hypersensitivity to linezolid or other components. 0 Consumption of high tyramine meals (>100mg per meal). INCLUSION CRITERIA MRSA Infection Parenteral Therapy (Select one indication and clinical scenario) - Documented MRSA pneumonia. - Documented complicated skin and skin structure infection caused by MRSA. - Other documented, serious MRSA infections. AND, one of the following clinical scenarios: 0 Infection is unresponsive to vancomycin despite therapeutic vancomycin concentrations. 0 In vitro non-susceptibility to vancomycin (including heteroresistant VISA strains) 0 Patient does not tolerate vancomycin (i.e., allergy or serious adverse drug reaction) and treatment with an oral agent (e.g., TMP/SMX, minocycline, doxycycline or clindamycin) is not appropriate. Oral therapy (Select one to be eligible) 0 Serious MRSA infection that requires oral therapy (e.g., IV to PO switch, without IV access) that cannot be treated by doxycycline, minocycline, TMP/SMX or clindamycin. Enterococcal Infection - parenteral or oral therapy (Select one to be eligible) 0 Documented vancomycin and ampicillin resistant Enterococcus infection. 0 Other documented, serious Enterococcal infections in a patient who does not tolerate ampicillin and vancomycin. July 2009 VISN 20 P&T	FORMULARY

AM900	LINEZOLID ORAL TABLETS	ZYVOX	Recommendation of Use for Linezolid (Zyvox) JUNE 2009 Pharmacy Benefits Management Services and the Medical Advisory Panel FDA APPROVED INDICATION(S) FOR USE - Community-acquired pneumonia caused by Streptococcus pneumoniae including patients with bacteremia and Staphylococcus aureus - Complicated skin and skin structure infections including diabetic foot infections without concurrent osteomyelitis caused by S. aureus, S. pyogenes, or S. agalactiae - Nosocomial pneumonia caused by S. aureus or S. pneumoniae - Uncomplicated skin and skin structure caused by S. aureus or S. pyogenes - Vancomycin-resistant Enterococcus faecium infections including concurrent bacteremia EXCLUSION CRITERIA (If one is selected, patient is NOT eligible) 0 Clinical evaluation of patient with positive microbiology culture(s) is consistent with colonization (not active infection). 0 Known resistance to linezolid. 0 Therapy for catheter-related bloodstream or catheter-site infections if the infection is not known to be due to only Gram-positive organisms(s). Contraindications: 0 Known hypersensitivity to linezolid or other components. 0 Consumption of high tyramine meals (>100mg per meal). INCLUSION CRITERIA MRSA Infection Parenteral Therapy (Select one indication and clinical scenario) - Documented MRSA pneumonia. - Documented complicated skin and skin structure infection caused by MRSA. - Other documented, serious MRSA infections. AND, one of the following clinical scenarios: 0 Infection is unresponsive to vancomycin despite therapeutic vancomycin concentrations. 0 In vitro non-susceptibility to vancomycin (including heteroresistant VISA strains) 0 Patient does not tolerate vancomycin (i.e., allergy or serious adverse drug reaction) and treatment with an oral agent (e.g., TMP/SMX, minocycline, doxycycline or clindamycin) is not appropriate. Oral therapy (Select one to be eligible) 0 Serious MRSA infection that requires oral therapy (e.g., IV to PO switch, without IV access) that cannot be treated by doxycycline, minocycline, TMP/SMX or clindamycin. Enterococcal Infection - parenteral or oral therapy (Select one to be eligible) 0 Documented vancomycin and ampicillin resistant Enterococcus infection. 0 Other documented, serious Enterococcal infections in a patient who does not tolerate ampicillin and vancomycin. July 2009 VISN 20 P&T	FORMULARY

AM900	LINEZOLID POWDER FOR ORAL SUSPENSION	ZYVOX	Recommendation of Use for Linezolid (Zyvox) JUNE 2009 Pharmacy Benefits Management Services and the Medical Advisory Panel FDA APPROVED INDICATION(S) FOR USE - Community-acquired pneumonia caused by Streptococcus pneumoniae including patients with bacteremia and Staphylococcus aureus - Complicated skin and skin structure infections including diabetic foot infections without concurrent osteomyelitis caused by S. aureus, S. pyogenes, or S. agalactiae - Nosocomial pneumonia caused by S. aureus or S. pneumoniae - Uncomplicated skin and skin structure caused by S. aureus or S. pyogenes - Vancomycin-resistant Enterococcus faecium infections including concurrent bacteremia EXCLUSION CRITERIA (If one is selected, patient is NOT eligible) 0 Clinical evaluation of patient with positive microbiology culture(s) is consistent with colonization (not active infection). 0 Known resistance to linezolid. 0 Therapy for catheter-related bloodstream or catheter-site infections if the infection is not known to be due to only Gram-positive organisms(s). Contraindications: 0 Known hypersensitivity to linezolid or other components. 0 Consumption of high tyramine meals (>100mg per meal). INCLUSION CRITERIA MRSA Infection Parenteral Therapy (Select one indication and clinical scenario) - Documented MRSA pneumonia. - Documented complicated skin and skin structure infection caused by MRSA. - Other documented, serious MRSA infections. AND, one of the following clinical scenarios: 0 Infection is unresponsive to vancomycin despite therapeutic vancomycin concentrations. 0 In vitro non-susceptibility to vancomycin (including heteroresistant VISA strains) 0 Patient does not tolerate vancomycin (i.e., allergy or serious adverse drug reaction) and treatment with an oral agent (e.g., TMP/SMX, minocycline, doxycycline or clindamycin) is not appropriate. Oral therapy (Select one to be eligible) 0 Serious MRSA infection that requires oral therapy (e.g., IV to PO switch, without IV access) that cannot be treated by doxycycline, minocycline, TMP/SMX or clindamycin. Enterococcal Infection - parenteral or oral therapy (Select one to be eligible) 0 Documented vancomycin and ampicillin resistant Enterococcus infection. 0 Other documented, serious Enterococcal infections in a patient who does not tolerate ampicillin and vancomycin. July 2009 VISN 20 P&T	FORMULARY

CV800	LISINOPRIL 5MG, 10MG, 20MG, 40MG TAB	ZESTRIL, PRINIVIL	Open Formulary - no restrictions	FORMULARY
CN750	LITHIUM CARBONATE 300MG CAP	ESKALITH	Open Formulary - no restrictions	FORMULARY
CN750	LITHIUM CITRATE SYRUP 300MG/5M	CIBALITH-S	Open Formulary - no restrictions	FORMULARY
CN750	LITHIUM TAB, REGULAR RELEASE	N/A	Open Formulary - no restrictions	FORMULARY
CN750	LITHIUM TAB, SA	LITHOBID	Open Formulary - no restrictions	FORMULARY
OP900	LODOXAMIDE TROMETHAMINE OPH SOLN	ALOMIDE	Open Formulary - no restrictions	FORMULARY
AN100	LOMUSTINE ORAL	CEENU	Restricted to Oncology Service or local equivalent	FORMULARY
GA400	LOPERAMIDE HCL 2MG CAP	IMMODIUM	Open Formulary - no restrictions	FORMULARY
PH000	LOPERAMIDE HCL LIQUID, ORAL	N/A	Open Formulary - no restrictions	FORMULARY
AM800	LOPINAVIR /RITONAVIR ORAL CAP	KALETRA	Restricted to HIV prescribers	FORMULARY
AH109	LORATADINE 10MG TAB	CLARITIN	Open Formulary - no restrictions	FORMULARY
CN302	LORAZEPAM 0.5MG, 1MG, 2MG TAB	ATIVAN	Open Formulary - no restrictions	FORMULARY
CN302	LORAZEPAM INJ 2MG/ML 1ML	ATIVAN	Open Formulary - no restrictions	FORMULARY
CV805	LOSARTAN ORAL	COZAAR	Angiotensin II Receptor Antagonist Criteria for Use in Veteran Patients I. Recommendations for Patients with Heart Failure (HF) - Valsartan Patients with systolic HF should be maximized on therapy with agents such as an angiotensin-converting enzyme inhibitor (ACEI), beta-adrenergic blocker, diuretic, and aldosterone antagonist, as indicated. Criteria for Angiotensin II Receptor Antagonist: Patient with systolic HF* (or HF/evidence of systolic dysfunction after acute MI) who is intolerant to an ACEI** Combination therapy with an ACEI (at optimal dose) and an angiotensin II receptor antagonist may be considered in patients with systolic HF*. However, due to conflicting data as to whether combination therapy of an AIIRA and ACEI, with or without a beta-adrenergic blocker, is of overall benefit in patients with systolic HF*, it is recommended that cardiology consultation or suitable alternative mechanism be established to evaluate the appropriateness of combination therapy based on the patient's clinical status and concomitant medications (note: combination therapy in patients with HF/evidence of systolic dysfunction after acute MI is not routinely recommended.) II. Recommendations for Patients with Diabetes Mellitus (DM) and Kidney Disease - Losartan Standard therapy for patients with DM and kidney disease includes treatment with an ACEI. As treatment with an angiotensin II receptor antagonist has been	FORMULARY

			shown to reduce the combined endpoint of increasing sCr, end-stage renal diseases (ESRD), and death in patients with type 2 DM and nephropathy with hypertension (HTN) and/or on antihypertensive medications, an angiotensin II receptor antagonist may be considered as another treatment option in this patient population. Combination therapy with an ACEI and angiotensin II receptor antagonist in patients with nondiabetic kidney disease with persistent proteinuria or microalbuminuria**** may be considered, although national treatment guidelines recommend the benefits be confirmed in other trials with a larger patient population. Criteria for Angiotensin II Receptor Antagonist: Patient with type 2 DM and nephropathy*** with HTN (or receiving antihypertensive medication) who is intolerant to an ACEI** National treatment guidelines have also recommended an angiotensin II receptor antagonist in patients with DM and kidney disease or nondiabetic kidney disease with proteinuria or microalbuminuriad who are intolerant to an ACEIb. Use of an angiotensin II receptor antagonist should be considered in patients who are intolerant to an ACEIb in this situation, although long-term survival data are not available. Combination therapy with an ACEI and angiotensin II receptor antagonist may be considered in patients with diabetic kidney disease with persistent proteinuria (> 1gm/day) or microalbuminuriad despite being appropriately titrated to an optimal dose of an ACEI (note: combination with an ACEI and nondihydropyridine calcium channel blocker may also be considered; if an angiotensin II receptor antagonist is prescribed in combination with an ACEI, the angiotensin II receptor antagonist should be discontinued if the patient does not respond, or experiences an adverse event such as hyperkalemia, as the long-term benefits and/or safety of this combination have not been established). III. Recommendations for Patients with HTN - Losartan As per national treatment guidelines, thiazide-type diuretics are the preferred agents for patients with uncomplicated HTN; other agents reported to have benefits in reducing morbidity or mortality should be considered in patients who have a contraindication to or are inadequately controlled [e.g., ACEI, beta-adrenergic blocker, or long-acting calcium channel blocker (CCB)]. These agents in turn can be used together or in combination with other selected agents to achieve goal blood pressure. An angiotensin II receptor antagonist	

			may be used as adjunct treatment or as specified below (also refer to Discussion section). In addition, angiotensin II receptor antagonists are appropriate in patients who have a compelling indication for an ACEI, but are intolerant to an ACEI (refer to Discussion section). Criteria for Angiotensin II Receptor Antagonist: p In a patient treated with an ACEI in combination therapy with other antihypertensive agents (e.g., thiazide-type diuretics, beta-adrenergic blockers, long-acting CCBs, etc), where the blood pressure is at or near goal, but is intolerant to the ACEI** ---- * Systolic HF = LVEF < 40% and New York Heart Association (NYHA) functional class II-IV. ** Intolerant to an ACEI = Unable to tolerate an ACEI due to cough or other non life-threatening reason. It is unknown if an angiotensin II receptor antagonist can be safely used as an alternative in patients who develop renal dysfunction, hyperkalemia, or angioedema with an ACEI; or where treatment with an ACEI is limited due to renal dysfunction, as these adverse events have also occurred with the use of an angiotensin II receptor antagonist (refer to Discussion section). *** Type 2 DM and nephropathy refers to patients with nephropathy (proteinuria > 0.5g/24h or microalbuminuriad) due to type 2 DM. **** 24 hour urine albumin collection > 30 mg/24 hours (Confirmed with 2-3 consecutive urine samples within a 3 month period separated by at least 1-2 weeks) or Spot urine albumin/creatinine ratio > 30mg urine albumin/gram urine creatinine (Confirmed with 2-3 consecutive urine samples within a 3 month period separated by at least 1-2 weeks). April 2005 Equivalent daily doses for ARB conversion: candesartan losartan valsartan 4 mg 25 mg 80 mg (40 mg bid) 8 mg 25 mg 80 mg (40 mg bid) 16 mg 50 mg 160 mg (80 mg bid) 32 mg 100 mg 320 mg (160 mg bid) April 2005 Recommendation for ARB to use in patients with systolic heart failure requiring combination therapy: (1) For patients requiring the combination of an ACEI, ARB, and beta-blocker, candesartan is the preferred ARB; and (2) For patients requiring the combination of an ACEI and ARB but not taking a beta-blocker, valsartan is the preferred ARB. This recommendation is only to guide the the choice of ARB in these situations, and is not meant to (mis)lead providers into pursuing an ACEI -ARB combination therapy before starting a beta blocker. June 2005	

CV350	LOVASTATIN ORAL TAB	MEVACOR	Simvastatin is the first line statin. Pravastatin is the preferred second line statin. Pravastatin and lovastatin are restricted to patients who cannot take simvastatin due to intolerance or drug interactions. Pharmacists have the authority to automatically convert prescriptions for lovastatin to simvastatin on a 2:1 (mg:mg) basis and lovastatin to pravastatin on a 1:1 (mg:mg) basis for patients unable to take simvastatin. September 2007, November 2008 VISN 20 P&T Committee	FORMULARY
CN709	LOXAPINE SUCCINATE 10MG, 25MG, 50MG CAP	LOXITANE	Open Formulary - no restrictions	FORMULARY
OP500	LUBRICATING OPH OINT	N/A	Open Formulary - no restrictions	FORMULARY
DE900	LUBRICATING TOP JELLY (OTC)	SURGILUBE	Open Formulary - no restrictions	FORMULARY
GA202	MAGNESIUM CITRATE LIQUID	CITROMA	Open Formulary - no restrictions	FORMULARY
TN406	MAGNESIUM OXIDE TAB (OTC)	MAG-OX	Open Formulary - no restrictions	FORMULARY
TN406	MAGNESIUM SULFATE INJ 8MEQ/2ML	N/A	Open Formulary - no restrictions	FORMULARY
CV709	MANNITOL 20% INJ 500ML	OSMITROL	Open Formulary - no restrictions	FORMULARY
CV709	MANNITOL 25% INJ 50ML	OSMITROL	Open Formulary - no restrictions	FORMULARY
MS102	MARAVIROC ORAL TAB	SELZENTRY	Criteria for Use: Maraviroc (Selzentry) VHA Pharmacy Benefits Management Services, Medical Advisory Panel and VISN Pharmacist Executives The following recommendations are based on current medical evidence. The content of the document is dynamic and will be revised as new clinical data become available. The purpose of this document is to assist practitioners in clinical decision making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. The clinician, however, must make the ultimate judgment regarding the propriety of any course of treatment in light on individual patient situations FDA APPROVED INDICATION FOR USE Maraviroc, in combination with other antiretroviral agents, is indicated for treatment of adults infected with only CCR5-tropic HIV-1. In treatment-naive subjects, more subjects treated with maraviroc experienced virologic failure compared to efavirenz. Tropism testing with a highly sensitive tropism assay is required for the appropriate use of maraviroc EXCLUSION CRITERIA (If one is selected, patient is NOT eligible) ??? Baseline tropism assay indicates the presence of CXCR4 or dual/mixed tropic virus ??? HIV-2 INCLUSION CRITERIA Use of maraviroc for treatment-experienced	FORMULARY

			patient (All must be selected for patient to be eligible) ??? Highly treatment-experienced patient (defined as at least 6 months of antiretroviral treatment and 3 class experience with at least one protease inhibitor failure) ??? Evidence of virologic failure (documented by a viral load >1,000 copies/mL) ??? Able to construct a multi-drug regimen that includes, preferably, at least one additional active antiretroviral drug (if available) in addition to maraviroc ??? Confirmed infection with CCR5 tropic virus (as determined by tropism assay result at screening) prior to maraviroc initiation. ??? Under the care of an experienced HIV practitioner Use of maraviroc for treatment-naive patient (All must be selected for patient to be eligible) ??? Unable to construct a multi-drug regimen from preferred, alternative, or acceptable regimens defined by Department Health and Human Services Guidelines for Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents (http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf) ??? Confirmed infection with CCR5 tropic virus (as determined by tropism assay result at screening) prior to maraviroc initiation. ??? Under the care of an experienced HIV practitioner DOSAGE AND ADMINISTRATION (Refer to PI for dosage recommendations in organ dysfunction) Due to drug-drug interactions, the recommended dose of maraviroc is guided by the presence of concomitantly administered medications. Maraviroc may be taken with or without food. Concomitant Medications Maraviroc dosage regimen CYP3A inhibitors (with or without CYP3A inducers) including protease inhibitors (except tipranavir/ritonavir), delavirdine, ketoconazole, itraconazole, clarithromycin, telithromycin and other strong CYP3A inhibitors (e.g., nefazadone) 150mg orally twice daily Other concomitant medications including tipranavir/ritonavir, raltegravir, NRTIs, nevirapine, enfuvirtide and drugs that are not strong CYP3A inhibitors or inducers 300mg orally twice daily CYP3A inducers including (without a strong CYP3A inhibitor) including efavirenz, etravirine, rifampin, carbamazepine, phenobarbital, phenytoin 600mg orally twice daily RECOMMENDED MONITORING In addition to standard monitoring in a patient receiving ART, 1) Baseline and frequent monitoring of LFTs particularly in patients with pre-existing liver dysfunction or co-infected with viral hepatitis B or C. 2) Baseline lipid panels should be obtained and monitored every 6	

			months. 3) Patients with signs and symptoms of hepatitis or allergic reaction following use of maraviroc should be evaluated immediately. Hepatotoxicity has been reported with maraviroc use. Evidence of a systemic allergic reaction (e.g., pruritic rash, eosinophilia, or elevated IgE) prior to the development of hepatotoxicity may occur. -Caution should be used in patients with increased risk of cardiovascular events. -Caution should be used in patients with a history of postural hypotension, concomitant medication known to lower blood pressure, or when administered with CYP3A4 inhibitors. -Patients should be monitored closely for evidence of infections. -Potential risk for malignancy ISSUES FOR CONSIDERATION - A highly sensitive tropism assay at baseline is required prior to initiation of maraviroc; the results of the tropism assay will take approximately 3 weeks and a prescription for maraviroc should not be written until the results indicate CCR5 tropism. - A repeat tropism assay should only be performed if the provider is considering a change of treatment due to increasing VL and/or decreasing CD4 count. If CXCR4 or DM virus is detected during therapy, maraviroc should generally be discontinued. In failing patients who have CCR5 virus, a maraviroc resistance assay may also be necessary. - Metabolized by CYP3A4 and is a P-gp substrate, therefore potential for drug interactions exist PBM Dec 2009 update	
XA900	MASK,SURGICAL	N/A	Open Formulary - no restrictions	FORMULARY
XA900	MASK,SURGICAL CUP SHAPE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
AP200	MEBENDAZOLE ORAL	VERMOX	Open Formulary - no restrictions	FORMULARY
AN100	MECHLORETHAMINE INJ	MUSTARGEN	Restrictions per local facility	FORMULARY
GA199	MECLIZINE HCL ORAL TAB		Open Formulary - no restrictions	FORMULARY
XA603	MEDICAL ADHESIVE H#7730 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	MEDICATION ORGANIZER	N/A	Open Formulary - no restrictions	FORMULARY
HS800	MEDROXYPROGESTERONE ACETATE INJ 150MCG/ML,400MG/ML	DEPO-PROVERA	Restrictions per local facility	FORMULARY
HS800	MEDROXYPROGESTERONE ACETATE ORAL	PROVERA	Open Formulary - no restrictions	FORMULARY
HS800	MEGESTROL ACETATE ORAL	MEGACE	Open Formulary - no restrictions	FORMULARY
MS102	MELOXICAM ORAL TAB	MOBIC	Open Formulary - no restrictions	FORMULARY
AN100	MELPHALAN HCL INJ	ALKERAN	Restrictions per local facility	FORMULARY

AN100	MELPHALAN ORAL	ALKERAN	Restricted to Oncology Service or local equivalent	FORMULARY
CN900	MEMANTINE HCL ORAL	NAMENDA	National VA Criteria for Use: Memantine to Treat Dementia Initial Prescription (all of the following must be met): 0 A diagnosis of Alzheimer's disease (AD) 0 The patient is determined to have moderate to severe AD as described in Stages 5 and 6 of the Functional Assessment Staging (FAST) scale OR is determined to have mild AD (FAST Stage 4) and has a contraindication or has demonstrated intolerance to cholinesterase inhibitors. http://vaww.national.cmop.va.gov/PBM/Clinical %20Guidance/Drug%20Monitoring /Functional %20Assessment%20Staging%20 (FAST)%207.31.08.doc 0 The patient is able to perform >1 activity of daily living with minimal assistance 0 The patient has a regular caregiver(s) to assist with medication and care or resides in a setting where assistance with medication administration is provided such as a nursing home. (FAST Stages 5 and 6) 0 The patient's medication regimen has been reviewed and all unnecessary anticholinergic medications have been discontinued. 0 No exclusion criteria are met. Renewal Every 6 Months (all of the following must be met): 0 The dementia diagnosis has not changed 0 The patient is taking a therapeutic dose 0 The patient is able to perform >1 activity of daily living with minimal assistance 0 The patient has a regular caregiver(s) to assist with medication and care 0 The patient and/or caregiver and prescriber agree that the patient has benefited from memantine and wish to continue, i.e., continuation is still in line with the goals of treatment and treatment targets. This discussion and decision are documented in the patient's medical record. 0 The patient's medication regimen has been reviewed and all unnecessary anticholinergic medications have been discontinued. 0 No exclusion criteria are met. Combination Treatment with Cholinesterase Inhibitor (both of the following must be met): 0 The patient meets all of the Initial Prescription criteria (see above) AND 0 Has been on a therapeutic dose of cholinesterase inhibitor or memantine for >6 months Exclusion Criteria (either of the following): 0 The patient is receiving dialysis or has a creatinine clearance	FORMULARY
IM100	MENINGOCOCCAL POLYSACCHARIDE VACCINE	MENOMUNE	Open Formulary - no restrictions	FORMULARY

DE650	MENTHOL/METHYL SALICYLATE 10-15% (LOW CONC) TOPICAL CREAM (OTC)	ANALGESIC CREAM	Open Formulary - no restrictions	FORMULARY
CN101	MEPERIDINE INJ 50MG/ML	DEMEROL	Open Formulary - no restrictions	FORMULARY
CN101	MEPERIDINE INJ 75MG/ML	DEMEROL	Open Formulary - no restrictions	FORMULARY
CN101	MEPERIDINE INJ 100MG/ML	DEMEROL	Open Formulary - no restrictions	FORMULARY
CN204	MEPIVACAINE HCL INJ	CARBOCAINE	Open Formulary - no restrictions	FORMULARY
AN300	MERCAPTOPURINE 50MG TAB	PURINETHOL	Restricted to Oncology Service or local equivalent	FORMULARY
GA900	MESALAMINE ORAL (CAP, SA & TAB,EC)	PENTASA	Mesalamine is formulary, restricted as second-line agent to sulfasalazine for patients with Crohn's disease WITHOUT ulcerative colitis. [Balsalazide is formulary, restricted as second-line agent to sulfasalazine for patients WITH ulcerative colitis, with or without Crohn's disease.] February 2008	FORMULARY
RS100	MESALAMINE RTL SUPP	ROWASA	Open Formulary - no restrictions	FORMULARY
AD900	MESNA INJ	MESNEX	Open Formulary - no restrictions	FORMULARY
HS200	MESTRANOL 50MCG/NORETHINDRONE 1MG TAB, 21 DAY	NORINYL 1/50	Open Formulary - no restrictions	FORMULARY
HS200	MESTRANOL 50MCG/NORETHINDRONE 1MG TAB, 28 DAY	NORINYL 1/50	Open Formulary - no restrictions	FORMULARY
HS502	METFORMIN HCL ORAL	GLUCOPHAGE	1. Metformin is open formulary, restricted to patients who meet the following safety constraints: (1) Patient must have no known contraindications to metformin (a) Renal insufficiency (serum creatinine >1.5 in men and >1.4 in women) (b) Evidence of hepatic impairment (c) Prior history of lactic acidosis, hypoxemia or metabolic acidosis (d) Cardiac insufficiency (e.g., CHF) (e) Acute or excessive alcohol ingestion (2) During severe illness or undergoing surgery, the patient's metformin should be discontinued until patient's renal function returns to baseline March 18, 2005 VISN 20 P&T Committee	FORMULARY
CN101	METHADONE 5MG TAB	DOLOPHINE	Open Formulary - no restrictions	FORMULARY

CN101	METHADONE ORAL SOLUTION 1MG/ML	DOLOPHINE	Open Formulary - no restrictions	FORMULARY
CV703	METHAZOLAMIDE 50MG TAB	NEPTAZANE	Acetazolamide sustained action (SA) tablets and capsules are non-formulary, second-line to regular release tablets. June 2008 VISN 20 P&T Commitee	FORMULARY
AM550	METHENAMINE MANDELATE/HIPPURATE ORAL TAB	MANDELAMINE	Open Formulary - no restrictions	FORMULARY
HS852	METHIMAZOLE ORAL	TAPAZOLE	Open Formulary - no restrictions	FORMULARY
MS200	METHOCARBAMOL 500MG TAB	ROBAXIN	Open Formulary - no restrictions	FORMULARY
MS200	METHOCARBAMOL 750MG TAB	ROBAXIN	Open Formulary - no restrictions	FORMULARY
CN202	METHOHEXITAL INJ	BREVITAL	Open Formulary - no restrictions	FORMULARY
AN300	METHOTREXATE NA INJ	RHEUMATREX	Restrictions per local facility	FORMULARY
AN300	METHOTREXATE NA ORAL	RHEUMATREX	Open Formulary - no restrictions	FORMULARY
DE801	METHOXSALEN ORAL	OXSORALEN	Restricted to Dermatology or local equivalent	FORMULARY
DE900	METHOXSALEN TOP LIQUID	OXSORALEN	Open Formulary - no restrictions	FORMULARY
CV490	METHYLDOPA ORAL	ALDOMET	Open Formulary - no restrictions	FORMULARY
CV490	METHYLDOPATE HCL INJ	ALDOMET ESTER	Open Formulary - no restrictions	FORMULARY
AD200	METHYLENE BLUE INJ	N/A	Open Formulary - no restrictions	FORMULARY
CN802	METHYLPHENIDATE 5MG, 10MG, 20MG TAB	RITALIN	Restricted to Neurology, Geriatrics, and Mental Health Services or local equivalent(s)	FORMULARY
CN802	METHYLPHENIDATE CAP,SA	RITALIN LA	Restricted to Neurology, Geriatrics, and Mental Health Services or local equivalent(s)	FORMULARY
CN802	METHYLPHENIDATE TAB,SA	CONCERTA	Restricted to Neurology, Geriatrics, and Mental Health Services or local equivalent(s)	FORMULARY
HS051	METHYLPREDNISOLONE ACETATE INJ	DEPO-MEDROL	Open Formulary - no restrictions	FORMULARY
HS051	METHYLPREDNISOLONE ORAL	MEDROL	Open Formulary - no restrictions	FORMULARY
HS051	METHYLPREDNISOLONE SODIUM SUCCINATE INJ	SOLU-MEDROL	Open Formulary - no restrictions	FORMULARY
AU300	METOCLOPRAMIDE HCL 10MG TAB	REGLAN	Open Formulary - no restrictions	FORMULARY
AU300	METOCLOPRAMIDE INJ 5MG/ML 2ML	REGLAN	Open Formulary - no restrictions	FORMULARY
AU300	METOCLOPRAMIDE SYRUP 5MG/5ML	REGLAN	Open Formulary - no restrictions	FORMULARY
CV701	METOLAZONE ORAL	ZAROXOLYN	Open Formulary - no restrictions	FORMULARY
CV100	METOPROLOL INJ	LOPRESSOR	Open Formulary - no restrictions	FORMULARY
CV100	METOPROLOL TARTRATE 50MG, 100MG TAB	LOPRESSOR	Open Formulary - no restrictions	FORMULARY

CV100	METOPROLOL XL EXTENDED RELEASE ORAL TAB	TOPROL	Extended-release metoprolol (Toprol XL) and bisoprolol are formulary, restricted to patients with Chronic Heart Failure.	FORMULARY
DE752	METRONIDAZOLE 0.75% TOP CREAM	FLAGYL	Metronidazole gel and 0.75% cream are both on VISN 20 and National Formularies. Topical metronidazole is open formulary, but facilities have the option to establish a preferred product.	FORMULARY
AM900	METRONIDAZOLE 250MG TAB	FLAGYL	Open Formulary - no restrictions	FORMULARY
AM900	METRONIDAZOLE INJ 500MG	FLAGYL	Open Formulary - no restrictions	FORMULARY
DE101	METRONIDAZOLE TOP GEL	METROGEL	Metronidazole gel and 0.75% cream are both on VISN 20 and National Formularies. Topical metronidazole is open formulary, but facilities have the option to establish a preferred product.	FORMULARY
GU300	METRONIDAZOLE VAG GEL	METROGEL VAGINAL	Open Formulary - no restrictions	FORMULARY
DX900	METYRAPONE ORAL	METOPIRONE	Open Formulary - no restrictions	FORMULARY
AM700	MICAFUNGIN INJ, LYOPHILIZED	MYCAMINE	Restricted to Infectious Disease Service and Transplant Service, or local equivalents.	FORMULARY
DE102	MICONAZOLE NITRATE 2% TOP PWDR	MICATIN	Open Formulary - no restrictions	FORMULARY
DE102	MICONAZOLE NITRATE 2% TOP TINCTURE	MONISTAT	Restricted to Dermatology or local equivalent	FORMULARY
MS300	MICONAZOLE TOPICAL CREAM	MICATIN	Open Formulary - no restrictions	FORMULARY
CN302	MIDAZOLAM HCL INJ	VERSED	Open Formulary - no restrictions	FORMULARY
CV900	MIDODRINE ORAL	PRO-AMATINE	Open Formulary - no restrictions	FORMULARY
GA202	MILK OF MAGNESIA 500ML	N/A	Open Formulary - no restrictions	FORMULARY
CV900	MILRINONE INJ	PRIMACOR	Restrictions per local facility	FORMULARY
RS300	MINERAL OIL ENEMA (OTC)	FLEETS	Open Formulary - no restrictions	FORMULARY
DE900	MINERAL OIL LIGHT 10ML STERILE	N/A	Open Formulary - no restrictions	FORMULARY
GA203	MINERAL OIL,HEAVY 100% LIQUID (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE350	MINERAL OIL/MINERAL WAX/PETROLATUM/WOOL WAX ALCOHOL	N/A	Open Formulary - no restrictions	FORMULARY
AM250	MINOCYCLINE HCL ORAL	MINOCIN	Open Formulary - no restrictions	FORMULARY
AM250	MINOCYCLINE MICROSPHERE POWDER	ARESTIN	Restricted to Dental Service	FORMULARY
CV490	MINOXIDIL 2.5MG, 10MG TAB	LONITEN	Open Formulary - no restrictions	FORMULARY
CN609	MIRTAZAPINE ORAL	REMERON	Restrictions per local facility	FORMULARY
GA309	MISOPROSTOL ORAL	CYTOTEC	Open Formulary - no restrictions	FORMULARY

AN200	MITOMYCIN INJ	MUTAMYCIN	Restrictions per local facility	FORMULARY
AN900	MITOTANE ORAL	LYSODREN	Restricted to Oncology Service or local equivalent	FORMULARY
AN900	MITOXANTRONE INJ	NOVANTRONE		FORMULARY
IM100	MMR II VACCINE	N/A	Open Formulary - no restrictions	FORMULARY
XA604	MOISTURE BARRIER SKIN OINT	N/A	Open Formulary - no restrictions	FORMULARY
XA604	MOISTURE BARRIER SKIN OINT H (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE350	MOISTURIZING LOTION (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CN709	MOLINDONE HCL ORAL	MOBAN	Open Formulary - no restrictions	FORMULARY
RE101	MOMETASONE FUROATE ORAL INHALER	ASMANEX	Open Formulary - no restrictions	FORMULARY
RE108	MONTELUKAST ORAL TABLET	SINGULAR	VA National Criteria for Use of Montelukast VHA Pharmacy Benefits Management Service and Medical Advisory Panel These criteria were based on the best clinical evidence currently available. The recommendations in this document are dynamic, and will be revised as new clinical information becomes available. This guidance is intended to assist practitioners in providing consistent, high-quality, cost-effective drug therapy. These criteria are not intended to interfere with clinical judgment; the clinician must ultimately decide the course of therapy based on individual patient situations. Exclusion Criteria O To treat acute asthma exacerbation O Patient has COPD only (e.g., does not have mixed COPD/asthma) There are insufficient data supporting the use of montelukast in COPD. Patients with features of both asthma and COPD may consider montelukast per criteria for use in asthma Inclusion Criteria for Persistent Asthma (must select as least one) O Patient is unable to use an inhaled corticosteroid (e.g., contraindication or adverse event) O Patient is on an inhaled corticosteroid and is unable to use a long-acting beta-agonist (e.g., contraindication or adverse event) for step up therapy NOTE: There is no evidence for additional benefit of montelukast in patients with asthma who are already on an inhaled corticosteroid AND long-acting beta-agonist; however, due to the adverse effects of chronic oral corticosteroids, a 1-2 month trial to assess responsiveness may be considered before maintenance oral corticosteroid therapy is initiated. Recommendations based on NHLBI Guidelines for the Diagnosis and Management of Asthma (EPR-3) http://www.nhlbi.nih.gov/guidelines/asthma/index.htm	FORMULARY

			Inclusion Criteria for Exercise-Induced Asthma (both must be selected) In general, pre-treatment with a short-acting beta agonist is considered the treatment of choice for preventing exercise-induced asthma O Patient has been evaluated for the need for initiation or optimization of chronic asthma therapy O Short acting beta agonist is not adequately effective; including situations where a metered dose inhaler cannot be used properly, exercise duration exceeds the duration of short-acting beta-agonist coverage, or regular /daily use is necessary (potential for tolerance). For prevention of exercise-induced asthma, a single dose should be taken at least 2 hours before exercise. All patients should still have a short-acting beta-agonist available in case of symptoms. Patients already taking one tablet daily for another indication (including chronic asthma) should not take an additional dose to prevent exercise-induced asthma. Inclusion Criteria for Allergic Rhinitis Monotherapy (both must be selected) O Patient is not a candidate for or has had an adverse event(s) to 2 nasal steroids O Patient has not responded to or is unable to tolerate oral 2nd generation antihistamines after a trial of 2 agents Combination Therapy (e.g., nasal steroid + montelukast OR antihistamine + montelukast) O Patient has had an insufficient response to combination therapy with a nasal steroid and a 2nd generation oral antihistamine (2 different agents from each category should be tried, if necessary, before concluding that there is insufficient response). OR O Combination therapy is desired but the patient is unable to tolerate one of the two classes of medications mentioned above after a trial of 2 different agents from the particular class) or the patient is physically unable to use a nasal steroid inhaler. NOTE: At present, there is no evidence for triple therapy use (antihistamine + nasal steroid + leukotriene modifying agents) Consider the use of an oral decongestant (or nasal decongestant if use is occasional or short-term /= 2 agents November 2008 (National), June 2009 (VISN 20 P&T)	
XA205	MONTGOMERY STRAPS	MONTGOMERY	Open Formulary - no restrictions	FORMULARY
CN101	MORPHINE SO4 ORAL IMMEDIATE RELEASE	N/A	Open Formulary - no restrictions	FORMULARY
CN101	MORPHINE SO4 ORAL SUSTAINED RELEASE: MS CONTIN OR AB RATED GENERIC	MS CONTIN OR AB RATED GENERIC	Restrictions per local facility	FORMULARY
CN101	MORPHINE SULFATE INJ 1, 2, 4,10,15 MG/ML	N/A	Open Formulary - no restrictions	FORMULARY

CN101	MORPHINE SULFATE INJ PCA 30MG/30ML, 150MG/ML	N/A	Open Formulary - no restrictions	FORMULARY
CV600	MORRHUATE INJ	SCLEROMATE	Restrictions per local facility	FORMULARY
OP210	MOXIFLOXACIN 0.5% OPHTHALMIC SOLUTION	VIGAMOX	Moxifloxacin ophthalmic solution is restricted to National Criteria: Patients must meet at least one of the following criteria: (1) Documented resistant ocular pathogens causing eye infections (2) Treatment of refractory conjunctivitis, corneal ulcers or keratitis (3) Patients undergoing eye surgery (cataract, corneal, retinal or refractive) to minimize risk of endophthalmitis (4) Atypical ocular infections (i.e., mycobacterium) November 2007 VISN 20 P&T Committee	FORMULARY
AM900	MOXIFLOXACIN 400MG ORAL TABLET	AVELOX	VA National Fluoroquinolone Criteria for Use Patient Selection: Please note that this document discusses the most common indications for fluoroquinolone use. It is not intended to be a comprehensive list of all appropriate uses of fluoroquinolones. Urinary tract infections: Due to antimicrobial resistance, in many medical centers fluoroquinolones are the antimicrobial of choice for empiric treatment of urinary tract infections. For this indication, based on safety, efficacy and price ciprofloxacin is the fluoroquinolone of choice. Community-acquired pneumonia: Hospitalized patients: First line therapy is generally with the combined use of a macrolide and a beta-lactam agent active against penicillin-resistant Streptococcus pneumoniae (e.g., cefotaxime or ceftriaxone). Fluoroquinolones should generally be considered second line agents for treatment of beta-lactam allergic patients. Outpatients: Use of fluoroquinolones requires radiological evidence of pneumonia and should be consistent with guidelines. Other upper and lower respiratory tract infections: Fluoroquinolones are generally second or third line agents based on the likely or proven susceptibility of known or probable infectious agents. Safety concerns with fluoroquinolone therapy involve the use of these agents in specific populations. O Patients with a history of long QT syndrome, hypokalemia or who are receiving Class Ia or class III antiarrhythmic agents (quinidine, disopyramide, procainamide, sotalol, amiodarone, dofetilide, ibutilide) are predisposed to development of Torsades de Pointes or other cardiac arrhythmias. These arrhythmias have been reported with levofloxacin, gatifloxacin and moxifloxacin. These fluoroquinolones should be avoided in this patient population. O Disturbances of blood glucose, including	FORMULARY

			symptomatic hypoglycemia and hyperglycemia, have been reported with all fluoroquinolones. The risk of dysglycemia is greatest in diabetic patients. However, hypoglycemia and particularly hyperglycemia have occurred in patients without a history of diabetes. Criteria for use of Levofloxacin - both IV and oral If the answer to either Indication for therapy or Identification of risk factors is yes the patient is eligible for levofloxacin therapy Indication for therapy Ventilator dependent pneumonia Y/N Healthcare associated pneumonia Y/N Identification of risk factors Patient at risk for P. aeruginosa; bronchectisis, cystic fibrosis, or previous antibiotic therapy within the past month? Y/N Patient shows no response to current antibiotic therapy? Y/N Levofloxacin dosage Healthcare associated/ventilator dependent pneumonia Normal renal function 750 mg IV daily* Impaired renal function Initial subsequent dosing Ccr 20 to 49 mL/min 750 mg 750 mg every 48 h Ccr 10 to 19 mL/min 750 mg 500 mg every 48 h Hemodialysis 750 mg 500 mg every 48 h CAPD 750 mg 500 mg every 48 h IV - intravenous, PO - orally * - patients may be transitioned to oral levofloxacin therapy when appropriate, either after receiving IV levofloxacin or other appropriate IV therapy. Local consensus protocols should be consulted for specific antibiotic choice(s) and for relevant approval processes in these circumstances. November 2006 VISN 20 P&T Committee	
AM900	MOXIFLOXACIN INJ	AVELOX	VA National Fluoroquinolone Criteria for Use Patient Selection: Please note that this document discusses the most common indications for fluoroquinolone use. It is not intended to be a comprehensive list of all appropriate uses of fluoroquinolones. Urinary tract infections: Due to antimicrobial resistance, in many medical centers fluoroquinolones are the antimicrobial of choice for empiric treatment of urinary tract infections. For this indication, based on safety, efficacy and price ciprofloxacin is the fluoroquinolone of choice. Community-acquired pneumonia: Hospitalized patients: First line therapy is generally with the combined use of a macrolide and a beta-lactam agent active against penicillin-resistant Streptococcus pneumoniae (e.g., cefotaxime or ceftriaxone). Fluoroquinolones should generally be considered second line agents for treatment of beta-lactam allergic patients. Outpatients: Use of fluoroquinolones requires radiological evidence of pneumonia and should be consistent with guidelines.	FORMULARY

			Other upper and lower respiratory tract infections: Fluoroquinolones are generally second or third line agents based on the likely or proven susceptibility of known or probable infectious agents. Safety concerns with fluoroquinolone therapy involve the use of these agents in specific populations. O Patients with a history of long QT syndrome, hypokalemia or who are receiving Class Ia or class III antiarrhythmic agents (quinidine, disopyramide, procainamide, sotalol, amiodarone, dofetilide, ibutilide) are predisposed to development of Torsades de Pointes or other cardiac arrhythmias. These arrhythmias have been reported with levofloxacin, gatifloxacin and moxifloxacin. These fluoroquinolones should be avoided in this patient population. O Disturbances of blood glucose, including symptomatic hypoglycemia and hyperglycemia, have been reported with all fluoroquinolones. The risk of dysglycemia is greatest in diabetic patients. However, hypoglycemia and particularly hyperglycemia have occurred in patients without a history of diabetes. Criteria for use of Levofloxacin - both IV and oral If the answer to either Indication for therapy or Identification of risk factors is yes the patient is eligible for levofloxacin therapy Indication for therapy Ventilator dependent pneumonia Y/N Healthcare associated pneumonia Y/N Identification of risk factors Patient at risk for P. aeruginosa; bronchectisis, cystic fibrosis, or previous antibiotic therapy within the past month? Y/N Patient shows no response to current antibiotic therapy? Y/N Levofloxacin dosage Healthcare associated/ventilator dependent pneumonia Normal renal function 750 mg IV daily* Impaired renal function Initial subsequent dosing Ccr 20 to 49 mL/min 750 mg 750 mg every 48 h Ccr 10 to 19 mL/min 750 mg 500 mg every 48 h Hemodialysis 750 mg 500 mg every 48 h CAPD 750 mg 500 mg every 48 h IV - intravenous, PO - orally * - patients may be transitioned to oral levofloxacin therapy when appropriate, either after receiving IV levofloxacin or other appropriate IV therapy. Local consensus protocols should be consulted for specific antibiotic choice(s) and for relevant approval processes in these circumstances. November 2006 VISN 20 P&T Committee	
XA900	MULTIDEX HYDROPHILIC WOUND DRESSING PWDR (OTC)	MULTIDEX	Open Formulary - no restrictions	FORMULARY
DX900	MULTISTIX 10 SG MULTIPLE TEST STRIP (OTC)	MULTISTIX	Open Formulary - no restrictions	FORMULARY

VT802	MULTIVITAMIN/MINERALS ORAL (OTC)	CENTRUM	Open Formulary - no restrictions	FORMULARY
VT802	MULTIVITAMIN/OPHTH ANTIOXIDANT/LUTEIN CAP/TAB	PRESERVISION LUTEIN & OTHERS	National criteria: Exclusion criteria (if one is selected, patient is NOT eligible): Category I ??? no AMD or Category II ??? early AMD. Inclusion criteria: Patient 50 years of age or older AND presence of extensive intermediate size drusen or one or more large drusen or non central geographic atrophy in at least 1 eye OR vision loss secondary to AMD (Category 3 and 4 AMD)] and Dry AMD and Non-smoking (patients should be non-smoking for > 1 year). * * Smoking patients who otherwise meet criteria should use the formulation without beta-carotene (MULTIVITAMIN/OPHTH ANTIOXIDANT/LUTEIN CAP/TAB)	FORMULARY
VT801	MULTIVITAMIN/OPTH AREDS SINGLE STRENGTH TAB	OCUVITE PRESERVISION, I-VITE & OTHERS	National criteria: Exclusion criteria (if one is selected, patient is NOT eligible): Category I ??? no AMD or Category II ??? early AMD. Inclusion criteria: Patient 50 years of age or older AND presence of extensive intermediate size drusen or one or more large drusen or non central geographic atrophy in at least 1 eye OR vision loss secondary to AMD (Category 3 and 4 AMD)] and Dry AMD and Non-smoking (patients should be non-smoking for > 1 year). * * Smoking patients who otherwise meet criteria should use the formulation without beta-carotene (MULTIVITAMIN/OPHTH ANTIOXIDANT/LUTEIN CAP/TAB)	FORMULARY
DX300	MUMPS SKIN TEST (MSTA) ANTIGEN INJ	N/A	Open Formulary - no restrictions	FORMULARY
DE101	MUPIROCIN TOPICAL OINT	BACTROBAN	Restricted to Infectious Disease, Renal Dialysis Unit, and preop for Cardiac/Vascular Surgery - or local facility equivalent.	FORMULARY
IM600	MUROMONAB-CD3 INJ	ORTHOCLONE OKT3	Restrictions per local facility	FORMULARY
VT801	MVI-12 INJ 10ML	N/A	Restrictions per local facility	FORMULARY
IM600	MYCOPHENOLATE INJ	CELLCEPT	Oral mycophenolate and mycophenolic acid are formulary, restricted for use by transplant services or local facility equivalent. Mycophenolate injection is restricted to use in patients who are unable to take the oral formulation. July 2004, June 2007	FORMULARY
IM600	MYCOPHENOLATE MOFETIL ORAL	CELLCEPT	Oral mycophenolate and mycophenolic acid are formulary, restricted for use by transplant services or local facility equivalent. Mycophenolate injection is restricted to use in patients who are unable to take the oral formulation. July 2004, June 2007	FORMULARY

IM600	MYCOPHENOLIC ACID EC TABLET	MYFORTIC	Oral mycophenolate and mycophenolic acid are formulary, restricted for use by transplant services or local facility equivalent. Mycophenolate injection is restricted to use in patients who are unable to take the oral formulation. July 2004, June 2007	FORMULARY
AM053	NAFCILLIN INJ 1GM/VIAL	UNIPEN	Open Formulary - no restrictions	FORMULARY
AM053	NAFCILLIN INJ 2GM/VIAL	UNIPEN	Open Formulary - no restrictions	FORMULARY
CN102	NALOXONE INJ 0.4MG/ML 1ML	NARCAN	Open Formulary - no restrictions	FORMULARY
CN102	NALTREXONE HCL ORAL	REVIA	Open Formulary - no restrictions	FORMULARY
HS100	NANDROLONE INJ	DECA-DURABOLIN	Restrictions per local facility	FORMULARY
OP800	NAPHAZOLINE OPHTH SOLUTION	ALBALON	Open Formulary - no restrictions	FORMULARY
OP900	NAPHAZOLINE/PHENIRAMINE OPHTH SOLUTION	NAPHCON-A	Open Formulary - no restrictions	FORMULARY
MS102	NAPROXEN 250MG TAB	NAPROSYN	Open Formulary - no restrictions	FORMULARY
XA900	NASAL OXYGEN TUBE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
IM700	NATALIZUMAB INJ	TYSABRI	Criteria for Use for Natalizumab in Multiple Sclerosis VHA Pharmacy Benefits Management Service and the Medical Advisory Panel Exclusion Criteria (if any apply, the patient DOES NOT qualify for natalizumab) 1) Patient has not been enrolled in and met all conditions of the TOUCH Prescribing Program 2) Patient is diagnosed with primary progressive multiple sclerosis 3) Patient is currently responsive to and tolerating another immunomodulatory treatment for MS 4) Patient has current or prior history of progressive multifocal leukoencephalopathy (PML); 5) Patient has a medical condition which significantly compromises the immune system including HIV infection or AIDS, leukemia, or lymphoma or organ transplantation; 6) Patient is currently receiving or has received in the previous three months chronic antineoplastics or immunosuppressants (i.e., adalimumab, alefacept alemtuzumab, anakinra, azathioprine, cladribine, cyclophosphamide, cyclosporine, daclizumab, efalizumab, etanercept, fludarabine phosphate, infliximab, intravenous immunoglobulin leflunomide, mercaptopurine, methotrexate, mycophenolate mofetil, mycophenolic acid, pemetrexed, rituximab, trastuzumab. 7) Patient is receiving any other immune system modifying drugs to treat MS (ie; interferon beta-1B, glatiramer acetate, interferon beta 1A, mitoxantrone) 8) Providers may exclude patients with melanoma or at high risk of developing melanoma or other cancers if in their	FORMULARY

			judgment treatment would pose a significant risk to the patient Inclusion Criteria 1) Patient has relapsing MS# characterized by disease activity defined as 2 or more relapses in the one year prior to therapy or gadolinium positive lesions on MRI*, despite disease modifying therapy Or 2) Patient has not demonstrated a clinical response during at least 4 weeks of therapy with glatiramer or interferon beta 1A or 1B (rapidly progressing MS) Or 3) Patient developed intolerance to therapy with both glatiramer and interferon beta and - Patients' currently receiving immunosuppressants or antineoplastics (see list above in exclusion criteria) should generally have a washout period of at least 3 months prior to initiation of natalizumab. The risks of a shorter washout period should be weighed against the risks of another relapse. - Patients receiving an interferon beta, glatiramer acetate, or corticosteroids should generally have a washout period of at least 2 weeks prior to initiation of natalizumab. Patients receiving an interferon beta, glatiramer acetate, or corticosteroids should generally have a washout period of at least 2 weeks prior to initiation of natalizumab. Patient initial registry completed and FAXed to MS Center of Excellence http://vaww.national.cmop.va.gov/PBM/Special%20Handling%20Drugs/Forms/AllItems.aspx) Dosage Recommendations The recommended dose of natalizumab for relapsing forms of MS is 300 mg by IV infusion over one hour every four weeks Monitoring Patients should be observed during the infusion and for one hour after the infusion is complete for signs or symptoms consistent with a hypersensitivity reaction. Natalizumab has been associated with hypersensitivity reactions, including serious systemic reaction which occurred at an incidence of < 1%. These reactions usually occur within 2 hours of the start of the infusion. There have been anecdotal reports of elevated hepatic transaminases and total bilirubin as early as six days post infusion. Liver enzymes and bilirubin should be monitored prior to each dose of natalizumab. Natalizumab induces increases in circulating leukocytes (including lymphocytes, monocytes, eosinophils, and basophils). It does not affect the number of circulating neutrophils. Since natalizumab has been causally linked with progressive multifocal leukoencephalopathy (PML), an opportunistic viral infection which leads to death or severe disability, suspected cases should be investigated with a	

			gadolinium enhanced MRI and when indicated a cerebrospinal fluid exam for JC viral DNA. Patients on natalizumab should be evaluated at 3 months and 6 months after the first infusion and every 6 months after that for clinical response, side effects, and any symptoms suggesting PML as well as a decision to continue natalizumab therapy. #Relapsing Forms of MS include: Relapsing, remitting MS: A clinical course of MS characterized by clearly defined, acute attacks with full or partial recovery and no disease progression between attacks. Secondary progressive MS with superimposed relapses: A clinical course of MS that shows steady progression but with superimposed acute relapses, after an initial relapsing-remitting course, Progressive-relapsing MS: A clinical course of MS that shows disease progression from the beginning, but with clear, acute relapses, with or without full recovery from those relapses. * gadolinium should not be used in patients with CrCl	
OP202	NATAMYCIN OPH SUSP	NATACYN	Restricted to Eye Clinic prescribers or local facility equivalent.	FORMULARY
XA856	NEEDLE	N/A	Open Formulary - no restrictions	FORMULARY
XA900	NEEDLE DISPOSAL CONTAINER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA856	NEEDLE PEN	N/A	Open Formulary - no restrictions	FORMULARY
AM800	NELFINAVIR ORAL	VIRACEPT	Restricted to HIV prescribers	FORMULARY
AM300	NEOMYCIN SULFATE 500MG TAB	MYCIFRADIN	Open Formulary - no restrictions	FORMULARY
IR100	NEOMYCIN/POLYMIXIN B IRRIG SOLN	NEOSPORIN GU	Open Formulary - no restrictions	FORMULARY
AU300	NEOSTIGMINE BROMIDE ORAL	PROSTIGMIN	Open Formulary - no restrictions	FORMULARY
AU300	NEOSTIGMINE INJ 0.5MG/ML	PROSTIGMIN	Open Formulary - no restrictions	FORMULARY
TN408	NEUTRA-PHOS 1.25G PACKET	NEUTRA-PHOS	Open Formulary - no restrictions	FORMULARY
AM800	NEVIRAPINE ORAL	VIRAMUNE	Restricted to ID Service or local equivalent	FORMULARY
VT103	NIACIN INJ	N/A	Open Formulary - no restrictions	FORMULARY

VT103	NIACIN ORAL, IMMEDIATE RELEASE (LEGEND)	NIACOR	(1) OTC niacin (both immediate release and sustained release) is non-formulary. Local facilities will determine whether a non-formulary request will be required to prescribe 100mg immediate release niacin for dosage titration. (not available as Rx) (2) Legend (Rx) immediate release niacin (Niacor) is open formulary, (3) Legend (Rx)sustained release niacin (Slo=Niacin) is open formulary; replaced Niaspan 5/2010 Feb 2007, May 2010	FORMULARY
VT103	NIACIN ORAL, SA (LEGEND)	NIASPAN	(1) OTC niacin (both immediate release and sustained release) is non-formulary. Local facilities will determine whether a non-formulary request will be required to prescribe 100mg immediate release niacin for dosage titration. (not available as Rx) (2) Legend (Rx) immediate release niacin (Niacor) is open formulary, (3) Legend (Rx)sustained release niacin (Slo=Niacin) is open formulary; replaced Niaspan 5/2010 Feb 2007, May 2010	FORMULARY
VT103	NIACINAMIDE ORAL	N/A	Open Formulary - no restrictions	FORMULARY
CV200	NICARDIPINE IV	CARDENE IV	Formulary, CFU	FORMULARY
AD900	NICOTINE GUM	NICORETTE	Open Formulary - no restrictions	FORMULARY
AD900	NICOTINE ORAL LOZENGES	COMMIT	Nicotine Lozenges (Commit) are formulary, first line therapy for smoking cessation when used alone and in combination with long-acting nicotine replacement (nicotine patch). July 2009 VISN 20 P&T Committee, April 2009 PBM/MAP Recommendations	FORMULARY
AD900	NICOTINE PATCH	NICODERM	Open Formulary - no restrictions	FORMULARY
CV200	NIFEDIPINE SA ORAL	ADALAT CC	Clinical Guidance for the Use of Formulary Long-Acting Dihydropyridine Calcium Channel Blockers VHA Pharmacy Benefits Management Strategic Healthcare Group and the Medical Advisory Panel The recommendations are based on current medical evidence and expert opinion from clinicians. The content of the document is dynamic and will be revised as new clinical data become available. The purpose of this document is to assist practitioners in clinical decision-making, to standardize and improve the quality of patient care, and to promote cost-effective drug prescribing. The clinician should utilize this guidance and interpret it in the clinical context of the individual patient. The following recommendations are provided for clinicians considering the use of a formulary long-acting dihydropyridine (LA DHP) calcium channel blocker (CCB) (e.g., amlodipine, felodipine,	FORMULARY

			long-acting nifedipine) for the treatment of hypertension (HTN) and/or angina. Short-acting nifedipine should not be used for these conditions. Hypertension (Amlodipine, Felodipine, or Long-Acting Nifedipine) Thiazide-type diuretics are the preferred first line agents for patients with uncomplicated HTN. In addition, most patients will require more than one agent to control their blood pressure. Another class of medication [e.g., angiotensin-converting enzyme inhibitor (ACEI), long-acting CCB] may be considered in patients who have a contraindication to or are inadequately controlled on a thiazide-type diuretic OR in patients who have an indication for an agent in another antihypertensive class (e.g., beta-blocker in a patient with prior-myocardial infarction or symptomatic coronary ischemia; ACEI and beta-blocker in patients with systolic heart failure). For additional information, refer to www.oqp.med.va.gov for the VHA/DoD Clinical Practice Guideline for Management of Hypertension in Primary Care. A formulary LA DHP may be considered in patients with HTN if they experience/have: - Inadequate control on a thiazide-type diuretic - Documented intolerance to a thiazide-type diuretic - Contraindication to a thiazide-type diuretic - Compelling indication for a LA DHP Angina (Amlodipine, Felodipine, or Long-Acting Nifedipine) Patients with angina should be treated with a beta-adrenergic blocker. A CCB may be an option when a beta-adrenergic blocker alone or in combination with a long-acting nitrate is ineffective or contraindicated. Selection of a non DHP CCB (e.g., diltiazem, verapamil) vs. a long-acting DHP in patients not on a beta-adrenergic blocker may depend on patient specific considerations. If a CCB is being considered in addition to therapy with a beta-adrenergic blocker, the long-acting DHP CCBs are preferred due to the potential for bradycardia or atrioventricular block with a non DHP CCB in combination with a beta-adrenergic blocker. A CCB may also be considered for additional blood pressure control and in patients with variant (Prinzmetal) angina. In addition, it is recommended that all patients with coronary artery disease who also have left ventricular systolic dysfunction and/or diabetes mellitus should be treated with an ACEI, unless contraindicated. For additional information, refer to www.oqp.med.va.gov for the VA/DoD Clinical Practice Guideline for Management of Ischemic Heart Disease. A formulary LA DHP may be considered in patients with angina if	

			they experience/have: - Inadequate control on a beta-adrenergic blocker - Documented intolerance to a beta-adrenergic blocker - Contraindication to a beta-adrenergic blocker - Variant (Prinzmetal) angina and unable to tolerate or do not respond to diltiazem or verapamil Hypertension and/or Angina in Patient with Concomitant Heart Failure (Amlodipine or Felodipine) Patients with systolic HF and concomitant HTN should be maximized on therapy with agents such as diuretics, ACEIs, and beta-adrenergic blockers, and an angiotensin II receptor antagonist (ARB), hydralazine/nitrate, or aldosterone antagonist, as indicated; or beta-adrenergic blockers and long-acting nitrates in patients with concomitant angina, before adding other agents. In patients not adequately controlled on these agents, treatment with amlodipine or felodipine may be considered; these recommendations are based on data in patients with HF treated with amlodipine (patients enrolled in PRAISE on amlodipine included ~ 81% in NYHA class III HF, 19% in class IV, with a mean ejection fraction 21%), and in another trial of patients with HF treated with felodipine (patients evaluated in V-HeFT III on felodipine included ~ 79% patients in NYHA class II HF, 22% in class III, with a mean ejection fraction 29%). The CCBs diltiazem, nifedipine, and verapamil should be avoided in patients with systolic dysfunction. For additional information, refer to www.oqp.med.va.gov for the PBM-MAP Pharmacologic Management of Patients with Chronic Heart Failure. A formulary LA DHP may be considered in the following clinical situations: - For the treatment of HTN in patients with concomitant HF who are not adequately controlled on, or have documented intolerance or a contraindication to a diuretic, ACEI, beta-adrenergic blocker, and ARB, hydralazine, or aldosterone antagonist, as indicated - For the treatment of angina in patients with concomitant HF who are not adequately controlled on, or have documented intolerance or a contraindication to a beta-adrenergic blocker and long-acting nitrate VISN 20 P&T Committee, August 2007	
DX900	NITRAZINE (pH) TEST STRIP	N/A	Open Formulary - no restrictions	FORMULARY
AM600	NITROFURANTOIN 100MG DUAL RELEASE CAP	MACROBID	Open Formulary - no restrictions	FORMULARY
CV250	NITROGLYCERIN PATCH	N/A	Open Formulary - no restrictions	FORMULARY
CV250	NITROGLYCERIN 0.3MG SL TAB	NITROSTAT	Open Formulary - no restrictions	FORMULARY

CV250	NITROGLYCERIN 0.4MG SL TAB	NITROSTAT	Open Formulary - no restrictions	FORMULARY
CV250	NITROGLYCERIN 0.6MG SL TAB	NITROSTAT	Open Formulary - no restrictions	FORMULARY
CV250	NITROGLYCERIN INJ 5MG/ML 10M	N/A	Open Formulary - no restrictions	FORMULARY
CV250	NITROGLYCERIN TOP OINT 2% 60GM	NITRO PASTE	Open Formulary - no restrictions	FORMULARY
CV490	NITROPRUSSIDE SODIUM INJ 50MG/ML	NIPRIDE	Restrictions per local facility	FORMULARY
HS900	NONOXYNOL 100MG VAG SUPP (OTC)	ORTHO-GYNOL	Open Formulary - no restrictions	FORMULARY
AU100	NOREPINEPHRINE INJ 1MG/ML	LEVOPHED	Open Formulary - no restrictions	FORMULARY
HS800	NORETHINDRONE 0.35MG TAB 28/PCKT	NOR-QD	Open Formulary - no restrictions	FORMULARY
CN601	NORTRIPTYLINE HCL 25MG, 50MG, 75MG CAP	PAMELOR	Open Formulary - no restrictions	FORMULARY
CN601	NORTRIPTYLINE ORAL SOLN	N/A	Open Formulary - no restrictions	FORMULARY
TN200	NUTITIONAL SUPPLEMENT OSMOLITE 1.0 AND 1.5	OSMOLITE	VISN 20 OUTPATIENT NUTRITIONAL SUPPLEMENT POLICY - July 7, 2005 DEFINITION: A nutritional supplement is defined as a commercially prepared product designed to be consumed in the place of food or in addition to foods. POLICY: A. Nutritional supplements that can be taken orally will not be prescribed for outpatient veterans. High risk patients should be referred to the Registered Dietitian (RD) (Attachment B) for instruction on appropriate diet intervention and/or food/supplement items available locally. B. Patients who indicate financial hardship may be referred to Social Work Services for information and referral to available community resources. C. The provision of enteral nutritional supplements for outpatients is limited to: (1) Patients receiving tube feeding. (2) Prescriptions for enteral nutritional supplements are limited to 12 months. Each new prescription or renewal for enteral nutritional supplements requires the completion of a new Enteral Nutritonal Supplement Recommendation Form. D. Criteria for receiving nutritional supplements also apply to fee basis patients. PROCEDURE: A. Non-tube feeding (oral) patients with a recent albumin less than 3, current BMI	FORMULARY
TN200	NUTRITION SUPL ENSURE PLUS/VANILLA ORAL LIQ	ENSURE PLUS	Restricted as per the VISN 20 Nutrition Supplement Policy: available for tube feeding or for patients unable to use powdered Ensure.	FORMULARY

TN200	NUTRITION SUPL ENSURE/VANILLA PWD (OTC)	ENSURE	VISN 20 OUTPATIENT NUTRITIONAL SUPPLEMENT POLICY - July 7, 2005 DEFINITION: A nutritional supplement is defined as a commercially prepared product designed to be consumed in the place of food or in addition to foods. POLICY: A. Nutritional supplements that can be taken orally will not be prescribed for outpatient veterans. High risk patients should be referred to the Registered Dietitian (RD) (Attachment B) for instruction on appropriate diet intervention and/or food/supplement items available locally. B. Patients who indicate financial hardship may be referred to Social Work Services for information and referral to available community resources. C. The provision of enteral nutritional supplements for outpatients is limited to: (1) Patients receiving tube feeding. (2) Prescriptions for enteral nutritional supplements are limited to 12 months. Each new prescription or renewal for enteral nutritional supplements requires the completion of a new Enteral Nutritonal Supplement Recommendation Form. D. Criteria for receiving nutritional supplements also apply to fee basis patients. PROCEDURE: A. Non-tube feeding (oral) patients with a recent albumin less than 3, current BMI	FORMULARY

TN200	NUTRITIONAL SUPPLEMENT JEVITY 1CAL	JEVITY	VISN 20 OUTPATIENT NUTRITIONAL SUPPLEMENT POLICY - July 7, 2005 DEFINITION: A nutritional supplement is defined as a commercially prepared product designed to be consumed in the place of food or in addition to foods. POLICY: A. Nutritional supplements that can be taken orally will not be prescribed for outpatient veterans. High risk patients should be referred to the Registered Dietitian (RD) (Attachment B) for instruction on appropriate diet intervention and/or food/supplement items available locally. B. Patients who indicate financial hardship may be referred to Social Work Services for information and referral to available community resources. C. The provision of enteral nutritional supplements for outpatients is limited to: (1) Patients receiving tube feeding. (2) Prescriptions for enteral nutritional supplements are limited to 12 months. Each new prescription or renewal for enteral nutritional supplements requires the completion of a new Enteral Nutritonal Supplement Recommendation Form. D. Criteria for receiving nutritional supplements also apply to fee basis patients. PROCEDURE: A. Non-tube feeding (oral) patients with a recent albumin less than 3, current BMI	FORMULARY
DE102	NYSTATIN 100,000 UNIT/GM TOP OINT	MYCOSTATIN	Open Formulary - no restrictions	FORMULARY
AM700	NYSTATIN ORAL SUSP 100,000U/ML	MYCOSTATIN	Open Formulary - no restrictions	FORMULARY
AM700	NYSTATIN ORAL/VAG TAB	MYCOSTATIN	Open Formulary - no restrictions	FORMULARY
DE102	NYSTATIN TOPICAL CREAM	MYCOSTATIN	Open Formulary - no restrictions	FORMULARY
GU300	NYSTATIN VAGINAL TAB 100,000U	MYCOSTATIN	Open Formulary - no restrictions	FORMULARY
DE350	OATMEAL, COLLOIDAL POWDER, TOPICAL (OTC)	AVEENO	Open Formulary - no restrictions	FORMULARY
DE900	OCCLUSIVE SKIN PROTECTANT (SENSI-CARE)	SENSI-CARE	Open Formulary - no restrictions	FORMULARY
GA400	OCTREOTIDE ACETATE 20MG/KIT, 30MG/KIT SA SUSP INJ	SANDOSTATIN	Restrictions per local facility	FORMULARY
GA400	OCTREOTIDE ACETATE INJ 0.05MG/ML (1ML)	SANDOSTATIN	Restrictions per local facility	FORMULARY
GA400	OCTREOTIDE ACETATE INJ 0.1MG/ML (1ML)	SANDOSTATIN	Restrictions per local facility	FORMULARY
GA400	OCTREOTIDE ACETATE INJ 0.2MG/ML (5ML)	SANDOSTATIN	Restrictions per local facility	FORMULARY
GA400	OCTREOTIDE ACETATE INJ 0.5MG/ML (1ML)	SANDOSTATIN	Restrictions per local facility	FORMULARY
GA400	OCTREOTIDE ACETATE INJ 1MG/ML (5ML)	SANDOSTATIN	Restrictions per local facility	FORMULARY

OT101	OFLOXACIN 0.3% OTIC SOLN	N/A	Open Formulary - no restrictions	FORMULARY
OP201	OFLOXACIN OPH SOLN	OCUFLOX	Restricted to prescriptions by Eye Clinic staff or local facility equivalent only if other agents are contraindicated or ineffective.	FORMULARY
CN709	OLANZAPINE INJ	ZYPREXA	Injectable aripiprazole and olanzapine are restricted to Mental Health/Psychiatry Service or local facility equivalent for use in patients receiving care in an emergency room or on an inpatient floor as monotherapy for the treatment of acute agitation associated with schizophrenia or bipolar I mania when the use of an oral antipsychotic is not feasible. November 2004, February 2008 VISN 20 P&T Committee	FORMULARY
CN709	OLANZAPINE ORAL	ZYPREXA	VISN 20 Guidelines for Atypical Antipsychotics Atypical antipsychotics are restricted to the treatment of first episode psychosis or chronic psychosis in relapse. (national guidelines) First (and 2nd) line atypical antipsychotics: (alphabetical, no prescribed hierarchy) Aripiprazole Quetiapine Risperidone Ziprasidone 3rd line Olanzapine Clozapine (if poor response to AT LEAST 2 other atypical antipchotics) April 2007 VISN 20 P&T Committee VISN 20 Guidelines for Screening and Monitoring Patients Prescribed Atypical Antipsychotics Baseline Screening Guidelines Prior to initiating a new atypical antipsychotic, it is recommended that clinicians:	FORMULARY

1. Obtain/review the patient's personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease.

2. Provide basic education about signs and symptoms of
Hyperglycemia
Diabetic ketoacidosis

3. Obtain or document in CPRS baseline measures for
Fasting lipid panel and fasting blood sugar (or an HgA1C if it is difficult to get the patient's cooperation for a fasting blood sugar)
Weight (entered into CPRS Cover Sheet)
Height (entered into CPRS Cover Sheet)
Blood pressure (entered into CPRS Cover Sheet)

Subsequent Monitoring Guidelines

During the first 4 months of treatment, it is recommended that clinicians:

1. Obtain a fasting blood sugar and lipid panel at least once.
2. Record weight at each visit; note any increases.
3. Record blood pressure at least once.

At one year of treatment, it is recommended that clinicians:

1. Make sure that a recent weight and blood pressure are recorded in
the chart.
2. Repeat fasting glucose.
3. Order a lipid panel if there are concerns about significant weight
gain, personal or family risk factors for cardiovascular disease, or
past abnormal laboratory results.

After one year, monitoring is at the clinician's discretion.

Considerations that would warrant further annual or more frequent
screening include:

			1. Significant amount of weight gain or pre-existing obesity 2. Family or personal history of other significant risk factors for cardiovascular disease or diabetes 3. Past abnormal laboratory screening results Summary of VISN 20 Screening and Monitoring Recommendations Measure Baseline First 4 Months One Year Personal/Family History Yes Review any changes Patient/Family Education Yes Height Yes Weight (BMI) Yes Each visit Yes Fasting glucose/ Hgb A1c Yes At least once Yes Fasting lipid profile Yes At least once If clinically indicated Blood pressure Yes At least once Yes June 2005 VISN 20 P&T	
GA900	OMEPRAZOLE 20MG SA CAP	PRILOSEC	Open Formulary - no restrictions	FORMULARY
GA605	ONDANSETRON INJECTION	ZOFRAN	Open Formulary - no restrictions	FORMULARY
GA700	ONDANSETRON ORAL	ZOFRAN	Open Formulary - no restrictions	FORMULARY
OP500	OPHTH LUBRICATING OINTMENT (PF) (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
OP109	Ophthalmic Prostaglandin Ophthalmic Solution		Formulary	FORMULARY
OR200	ORABASE PLAIN PASTE (OTC)	ORABASE	Open Formulary - no restrictions	FORMULARY
HS200	ORTHO-NOVUM 7/7/7 TAB 21,28 DAY PACK (GENERIC)	ORTHO-NOVUM	Ortho Novum 7/7/7-28 is restricted to women unable to take Tri-Levlen-28 June 1998	FORMULARY
AM800	OSELTAMIVIR ORAL	TAMIFLU	Criteria for Use of Antiviral Agents for Influenza December 2009 VHA Pharmacy Benefits Management Service and the Medical Advisory Panel VA RECOMMENDATION FOR CHEMOPROPHYLAXIS AND TREATMENT OF 2009 H1N1 AND SEASONAL INFLUENZA Recommendations for 2009 H1N1 and seasonal influenza are dynamic; recommendations for use of antiviral medications may change as data on antiviral effectiveness, clinical spectrum of illness, adverse events from antiviral use, or resistance among circulating viruses become available. Providers and	FORMULARY

			local facilities will need to coordinate implementation of these guidelines with any updated CDC and/or local health department recommendations. Chemoprophylaxis for Influenza Based upon CDC interim recommendations for antiviral chemoprophylaxis, the VA recommends oseltamivir or zanamivir be considered in persons exposed to 2009 H1N1 or seasonal influenza as described below. Persons who are at higher risk for complications of influenza (including pregnant women) and are an unprotected close contact of a person with confirmed, probable, or suspected 2009 H1N1 or seasonal influenza during that person's infectious period. Health care personnel, public health workers, or first responders who have had a recognized, unprotected close contact exposure to a person with confirmed, probable, or suspected 2009 H1N1 or seasonal influenza during that person's infectious period. Chemoprophylaxis of healthcare workers should be prescribed in consultation with occupational health Antiviral agents should NOT be used for post exposure chemoprophylaxis in healthy children or adults based on potential exposures in the community, school, camp or other settings. Chemoprophylaxis generally is not recommended if more than 48 hours have elapsed since the last contact with an infectious person. Chemoprophylaxis is not indicated when contact occurred before or after, the ill person's infectious period. Outbreaks in Nursing Homes When 2009 H1N1 outbreaks occur, it is recommended that ill patients be treated with oseltamivir or zanamivir and that chemoprophylaxis with either oseltamivir or zanamivir be started as early as possible to reduce the spread of the virus as is recommended for seasonal influenza outbreaks in such settings. Outbreaks of seasonal influenza may be more likely in nursing homes and may require chemoprophylaxis with oseltamivir and/or an olchicine depending on whether the outbreak were due to seasonal H1N1 (resistant to oseltamivir) or to seasonal H3N2 or influenza B (both of which are resistant to the adamantanes). If the type of seasonal influenza is not known, chemoprophylaxis should consist of oseltamivir plus an olchicine. Treatment for Influenza As of December 4, 2009, 99% of circulating influenza viruses were 2009 H1N1 viruses susceptible to both oseltamivir and zanamivir. The CDC (and VA) treatment recommendations therefore focus on use of antiviral medications effective against 2009 H1N1	

			viruses. Based upon the CDC recommendations for antiviral treatment, the VA recommends oseltamivir or zanamivir should be used in patients with confirmed, probable or suspected 2009 H1N1 or seasonal influenza and one of the following: Illness requiring hospitalization Progressive, severe, or complicated illness, regardless of previous health status Patients at risk for severe disease Other treatment considerations: Once the decision to administer antiviral treatment is made by the health care provider, treatment with zanamivir or oseltamivir should be initiated as soon as possible even before definitive diagnostic test results become available (i.e., treatment should not wait for laboratory confirmation of influenza). Evidence for benefits from antiviral treatment in studies of uncomplicated seasonal influenza is strongest when treatment is started within 48 hours of illness onset. Initiating treatment as soon as possible after illness onset is also thought likely to reduce the risk of severe outcomes including severe illness or death. However, some studies of hospitalized patients with seasonal influenza treated with oseltamivir have suggested benefit, including reductions in mortality or duration of hospitalization, even for patients whose treatment was started more than 48 hours after illness onset. Clinicians should consider the possibility of bacterial coinfections that can occur during or after an influenza illness. In October 2009, monovalent inactivated and live attenuated 2009 H1N1 influenza vaccines became available in the United States. Although these vaccines are expected to be highly effective, no vaccine is 100% effective. Therefore, a history of receipt of 2009 H1N1 or seasonal influenza vaccine does not rule out influenza infection. Early empiric treatment should be initiated for vaccinated persons with suspected influenza infection when indicated (e.g. persons requiring hospitalization, with severe infection, or at higher risk for influenza-related complications). Vaccination with 2009 H1N1 influenza vaccine is not expected to provide protection against infection with seasonal influenza A or B viruses. Similarly, vaccination with seasonal influenza vaccine is not expected to prevent infection with 2009 H1N1 influenza virus. Intravenous Peramivir has been authorized for use by the FDA, subject to the Emergency Use Authorization (EUA) terms and conditions. Specifically, peramivir is authorized for the following patients who are admitted to a hospital: Adult patients for whom	

			therapy with an IV agent is clinically appropriate, based upon one or more of the following reasons: o patient not responding to either oral or inhaled antiviral therapy, or o drug delivery by a route other than IV (e.g. enteral oseltamivir or inhaled zanamivir) is not expected to be dependable or is not feasible, or o the clinician judges IV therapy is appropriate due to other circumstances. Pediatric patients for whom an IV agent is clinically appropriate because: o patient not responding to either oral or inhaled antiviral therapy, or o drug delivery by a route other than IV (e.g. enteral oseltamivir or inhaled zanamivir) is not expected to be dependable or is not feasible To request peramivir under the EUA for a specific patient, the request process can be initiated via http://www.cdc.gov/h1n1flu/eua/peramivir.htm Treatment of influenza when oseltamivir-resistant viruses are circulating Oseltamivir resistance is common among seasonal influenza A (H1N1) viruses. These seasonal H1N1 viruses typically remain susceptible to rimantadine and amantadine. However, since April 2009, very few seasonal H1N1 viruses have circulated in the United States. Therefore, treatment, when indicated, with either oseltamivir or zanamivir is appropriate. However, if viral surveillance data indicate that oseltamivir-resistant seasonal H1N1 viruses have become more common or are associated with identified community outbreaks, zanamivir or a combination of oseltamivir and rimantadine or amantadine should be considered for use as empiric treatment for patients who might have oseltamivir-resistant seasonal human influenza A (H1N1) virus infection. Table 1. Definitions for Influenza Infection Influenza-like-illness (ILI) is defined as fever (temperature of 100F [37.8C] or greater) and a cough and/or a sore throat in the absence of a KNOWN cause other than influenza. Infectious period for a confirmed case of influenza virus infection is defined as 1 day prior to the case's illness onset to 7 days after onset. Close contact is defined as having cared for or lived with a person who is a confirmed, probable or suspected case of influenza, or having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of such a person. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, physical examination, or any other contact between persons likely to result in exposure to respiratory droplets. Table 2. Definition of High-Risk	

			Groups for 2009 Influenza (H1N1) and Seasonal Influenza High-risk groups: A person who is at high-risk for complications of 2009 H1N1 virus infection is defined as the same for seasonal influenza at this time. Adults 65 years of age and older. Persons with the following conditions: o Chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological (including sickle cell disease), neurologic, neuromuscular, or metabolic disorders (including diabetes mellitus); o Immunosuppression, including that caused by medications or by HIV; o Pregnant women**; o Persons younger than 19 years of age who are receiving long-term aspirin therapy; o Residents of nursing homes and other chronic-care facilities. Children younger than 5 years old. The risk for severe complications from seasonal influenza is highest among children younger than 2 years old. Preliminary studies suggest that people who are morbidly obese (body mass index equal to or greater than 40) and perhaps people who are obese (body mass index 30 to 39) may be at increased risk of hospitalization and death due to 2009 H1N1 influenza infection. Additional studies to determine the risk of morbid obesity and /or obesity for these complications of 2009 H1N1 virus infection are underway. Patients with morbid obesity, and perhaps obesity, often have underlying conditions that put them at increased risk for complications due to 2009 H1N1 influenza infection, such as diabetes, asthma, chronic respiratory illness or liver disease. ** Refer to consideration in pregnant women for further discussion Consideration in Pregnant Women Pregnant women are known to be at higher risk for complications from infection with seasonal influenza viruses, and severe disease among pregnant women was reported during past pandemics. Hospitalizations and deaths have been reported among pregnant women with 2009 H1N1 influenza virus infection, and one study estimated that the risk for hospitalization for 2009 H1N1 influenza was four times higher for pregnant women than for the general population. While oseltamivir and zanamivir are Pregnancy Category C medications, indicating that no clinical studies have been conducted to assess the safety of these medications for pregnant women, the available risk-benefit data indicate pregnant women with suspected or confirmed influenza should receive prompt antiviral therapy. Pregnancy should not be considered a contraindication to oseltamivir or zanamivir use.	

			Because of its systemic activity, oseltamivir is preferred for treatment of pregnant women. The drug of choice for chemoprophylaxis is less clear. Zanamivir may be preferable because of its limited systemic absorption; however, respiratory complications that may be associated with zanamivir because of its inhaled route of administration need to be considered, especially in women at risk for respiratory problems. . . Table 3: Recommended Daily Adult Dosages of Novel Influenza (2009 HIN1) and Seasonal Influenza Antiviral Medications for Treatment and Chemoprophylaxis Antiviral Agent: Zanamivir Treatment, influenza A and B 18-64 yrs old 10 mg (2 inhalations) twice daily for 5 days 65 and older 10 mg (2 inhalations) twice daily for 5 days Renal and Hepatic dysfunction No dosage reduction is recommended for patients with mild, moderate and severe renal impairment. However, the potential for drug accumulation should be considered in patients with severe renal insufficiency. Zanamivir has not been studied in patients with liver disease. Prophylaxis, influenza A and B 18-64 yrs old 10 mg (2 inhalations) once daily for 10 days 65 and older 10 mg (2 inhalations) once daily for 10 days Antiviral Agent: Oseltamivir Treatment, influenza A and B 18-64 yrs old 75 mg twice daily for 5 days 65 and older 75 mg twice daily for 5 days Renal and Hepatic dysfunction CrCl 10-30 ml/min: 75 mg once daily CAPDc: 30 mg once weekly Hemodialysis (note c): 30 mg after every other session Oseltamivir has not been studied in patients with liver disease. Prophylaxis, influenza A and B 18-64 yrs old 75 mg once daily for 10 daysa 65 and older 75 mg once daily for 10 daysa Renal and Hepatic dysfunction CrCl 10 - 30 ml/min: 75 mg every other day or 30 mg once daily Antiviral Agent: Amantadine Treatment, influenza A 18-64 yrs old 100 mg twice daily for 5 days 65 and older 100 mg/day for 5 days Renal and Hepatic dysfunction CrCl	
XA606	OSTOMY DEODORANT TABLET	WHO NOZ	Open Formulary - no restrictions	FORMULARY
XA604	OSTOMY PASTE	N/A	Open Formulary - no restrictions	FORMULARY
XA606	OSTOMY POUCH DEODORANT	N/A	Open Formulary - no restrictions	FORMULARY
XA604	OSTOMY SKIN PROTECTIVE POWDER	N/A	Open Formulary - no restrictions	FORMULARY
DX900	OVULATION PREDICTOR KIT	OVUQUICK ONE STEP 9	Restricted to Women's Health providers or local facility equivalent.	FORMULARY
AM112	OXACILLIN INJ	N/A	Open Formulary - no restrictions	FORMULARY

AN900	OXALIPLATIN INJ	ELOXATIN	Restricted to Hematology/Oncology or local facility equivalent as second-line therapy in recurrent or progressive metastatic colorectal cancer. Feb 2003, July 2004	FORMULARY
GU201	OXYBUTYNIN CHLORIDE 5MG TAB	DITROPAN	Open Formulary - no restrictions	FORMULARY
GU201	OXYBUTYNIN EXTENDED RELEASE	DITROPAN XL	FORMULARY	FORMULARY
CN101	OXYCODONE HCL ORAL REGULAR RELEASE	N/A	Open Formulary - no restrictions	FORMULARY
CN101	OXYCODONE HCL/ACETAMINOPHEN ORAL	PERCOCET	Open Formulary - no restrictions	FORMULARY
NT100	OXYMETAZOLINE HCL 0.05% NASAL	AFRIN	Open Formulary - no restrictions	FORMULARY
AN900	PACLITAXEL INJ	TAXOL	Restrictions per local facility	FORMULARY
XA101	PAD ABDOMINAL STERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA105	PAD ANTISEPTIC	N/A	Open Formulary - no restrictions	FORMULARY
XA105	PAD BISMUTH ANTISEPTIC (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA103	PAD NON-ADHESIVE STREILE	N/A	Open Formulary - no restrictions	FORMULARY
XA104	PAD W/ADHESIVE STERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA103	PAD, NON-ADHERANT, DRY	N/A	Open Formulary - no restrictions	FORMULARY
XA103	PAD, NON-ADHERING	N/A	Open Formulary - no restrictions	FORMULARY
XA102	PAD,ABDOMINAL NONSTERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA102	PAD,ABDOMINAL STERILE	N/A	Open Formulary - no restrictions	FORMULARY
XA104	PAD,FOAM (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA110	PAD,FOAM SELF-ADHERE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
HS900	PAMIDRONATE INJ 30MG/VIAL	AREDIA	Open Formulary - no restrictions	FORMULARY
GA500	PANCREATIC ENZYMES	VIOKASE	Open Formulary - no restrictions	FORMULARY
MD300	PANCURONIUM INJ	PAVULON	Restrictions per local facility	FORMULARY
DE802	PAPILLOMA VIRUS VACCINE INJ	GARDASIL	Quadrivalent HPV Vaccine Criteria for Use August 2010 The Product Information should be consulted for detailed prescribing information. Exclusion Criteria If ANY item below applies, then the patient should NOT receive vaccine. • Female or male greater than 26 years of age • Pregnant or may be pregnant • Individuals with a history of immediate	FORMULARY

			hypersensitivity to yeast or other components of the vaccine • Moderate or severe acute illnesses (vaccination should be deferred until after the patient improves) Inclusion Criteria One of the following criteria must be met in order for a patient to receive the vaccine. • Female 9-26 years of age if unvaccinated or not completed 3-dose series. • Male 9-26 years of age if unvaccinated or not completed 3-dose series. Dosage and Administration Quadrivalent Human Papillomavirus vaccine is administered intramuscularly as 3 separate 0.5 ml doses. The first dose is followed by 2 additional doses given at 2 and 6 months after the initial dose. Issues for Consideration • For females, ACIP recommends routine vaccination of females aged 11 or 12 years and catch-up vaccination for females aged 13 through 26 years old. • For males, ACIP provided guidance that HPV4 may be given to males aged 9 through 26 years to reduce their likelihood of acquiring genital warts; however, ACIP does not recommend HPV4 for routine use among males. Since routine use is not recommended for males by ACIP, provider should discuss with male patient the potential risks and benefits of vaccination, and burden of HPV-associated diseases and cancers in males and a shared decision should be made for use. • It is not recommended to test for HPV infection prior to vaccination as testing only indicates current but not past infection. • The quadrivalent Human Papillomavirus vaccine can be administered to persons with a his¬tory of genital warts, abnormal Papanicolaou test, or positive HPV DNA test, because these conditions are not evidence of prior infection with all vaccine HPV types. • The importance of continued routine cervical cancer screening with Pap smear tests should be reinforced in both vaccinated and unvaccinated women. • Syncope (i.e., vasovagal or vasodepressor reaction) has been reported following vaccination and may result in falling and traumatic injury; health care providers should observe vaccinee for 15 minutes after administration. These falls and injuries may be prevented by having vaccinee seated or lying down for 15 minutes following vaccination, and closely observing her for signs and symptoms that may occur before	

			fainting including paleness, sweating, dizziness, ringing in ears or vision changes. Syncope may be associated with tonic-clonic movements or other seizure-like activity; the activity is usually transient and typically responds to restoring cerebral perfusion by maintaining a supine or Trendelenburg position. • Patient information related to the quadrivalent HPV vaccine is available through CDC: http://www.cdc.gov/vaccines/pubs/vis/default.htm#hpv Prepared: April 2007; Updated August 2009, August 2010. Contact: Melinda Neuhauser, PharmD, MPH, VA Pharmacy Benefits Management Services	
GA400	PAREGORIC	N/A	Open Formulary - no restrictions	FORMULARY
CN609	PAROXETINE HCL 10MG, 20MG, 30MG, 40MG TAB	PAXIL	Open Formulary - no restrictions	FORMULARY
XA604	PASTE,STOMAHESIVE (OTC)	STOMAHESIVE	Open Formulary - no restrictions	FORMULARY
GA202	PEG-3350/ELECTROLYTES POWDER	COLYTE; GOLYTELY	Open Formulary - no restrictions	FORMULARY
IM700	PEG-INTERFERON ALFA-2B INJ	PEGINTRON	Open Formulary - no restrictions	FORMULARY
IM700	PEGYLATED INTERFERON ALFA 2A INJ	PEGASYS	Open Formulary - no restrictions	FORMULARY
MS104	PENICILLAMINE 250MG TAB	CUPRIMINE	Open Formulary - no restrictions	FORMULARY
AM051	PENICILLIN G BENZATHINE INJ 1.2 MU	BICILLIN	Open Formulary - no restrictions	FORMULARY
AM051	PENICILLIN G POTASSIUM INJ 5 MU	PFIZERPEN	Open Formulary - no restrictions	FORMULARY
AM051	PENICILLIN G POTASSIUM INJ 20 MU	PFIZERPEN	Open Formulary - no restrictions	FORMULARY
AM051	PENICILLIN G PROCAINE INJ 0.6 MU	WYCILLIN	Open Formulary - no restrictions	FORMULARY
AM051	PENICILLIN G PROCAINE INJ 1.2 MU	WYCILLIN	Open Formulary - no restrictions	FORMULARY
AM051	PENICILLIN G SODIUM INJ 5 MU	PFIZERPEN	Open Formulary - no restrictions	FORMULARY
AM051	PENICILLIN VK 250MG TAB	PENVEEK	Open Formulary - no restrictions	FORMULARY
AM051	PENICILLIN VK SUSP 250MG/5ML 100ML	PENVEE-K	Open Formulary - no restrictions	FORMULARY
DE700	PENTAFLUOROPROPANE/TETRAFLUOROETHANE TOP AEROSAL	GEBAUER SPRAY AND STRETCH	Open Formulary - no restrictions	FORMULARY
AP109	PENTAMIDINE ISETHIONATE INHL SOLN	NEBUPENT	Restricted to HIV prescribers and Infectious Disease Service or local equivalent(s).	FORMULARY
AM900	PENTAMIDINE ISETHIONATE INJ	PENTAM	Restrictions per local facility	FORMULARY
AN900	PENTOSTATIN INJ	NIPENT	Restrictions per local facility	FORMULARY
AN900	PENTOSTATIN/MANNITOL INJ	NEMBUTAL	Restrictions per local facility	FORMULARY

DE900	PERINEAL WASH (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	PERI-WASH II CLEANSER (OTC)	PERI-WASH II	Open Formulary - no restrictions	FORMULARY
AP900	PERMETHRIN CREAM	ELIMITE	Open Formulary - no restrictions	FORMULARY
AP300	PERMETHRIN TOP LOTION (OTC)	NIX CREAM RINSE	Open Formulary - no restrictions	FORMULARY
CN701	PERPHENAZINE 2MG, 4MG, 8MG TAB	TRILAFON	Open Formulary - no restrictions	FORMULARY
DE350	PETROLATUM, WHITE	N/A	Open Formulary - no restrictions	FORMULARY
GU100	PHENAZOPYRIDINE HCL 100MG TAB	PYRIDIUM	Open Formulary - no restrictions	FORMULARY
CN602	PHENELZINE SULFATE ORAL	NARDIL	RESTRICTION(S) AND OTHER INFORMATION: VHA MAP/PBM-SHG Criteria-for-Use: Monoamine Oxidase Inhibitors (MAOI) for the Treatment of Major Depressive Disorder Oral and Transdermal Routes of Administration The criteria-for-use apply to all MAOIs prescribed for the treatment of major depressive disorder regardless of route of administration. Please note at the time the criteria were developed no information was available on the efficacy or safety of transdermal selegiline for conditions other than major depressive disorder. The criteria do not apply to oral MAOIs being used to treat other conditions such as: Anxiety disorders; bipolar disorder; dysthymia; and Parkinson's disease (oral selegiline only). In order to receive an MAOI for the treatment of major depressive disorder, patients should meet the following: Have a diagnosis of major depressive disorder AND Have a prescription/order written by a psychiatrist or mental health provider AND Have failed to achieve remission (the absence of depressive symptoms or the presence of minimal depressive symptoms) after trials of two different antidepressants at therapeutic doses for at least 6 weeks OR Have demonstrated a therapeutic response to an MAOI in the past. PLUS ALL of the following must be met: The patient has no current contraindications to an MAOI (e.g., designated opiates, serotonin-active medications). See next page. The patient has not taken another antidepressant for a minimum of 2-5 weeks (see individual antidepressant labeling for specific washout period) prior to starting an MAOI. The patient demonstrates an understanding of and is willing to comply with the required dietary, herbal, and over-the-counter medications restrictions while taking an MAOI. The clinician-prescriber is willing or the facility has a system in place to answer the patient's questions about the medication 24 hours a	FORMULARY

			day to avoid drug-drug and drug-food interactions. *The transdermal selegiline patch should not be cut. All MAOIs for depresssion (oral and patch) are restricted to psychiatry/mental health providers. Contraindications to MAOIs: Dietary sources rich in tyramine: Meat, Poultry and Fish o Air dried, aged, and fermented meats, sausages, salamis o Pickled herring o Spoiled or improperly stored meat, poultry or fish, including liver Vegetables o Broad bean pods, e.g., fava bean pods Dairy (milk products) o Aged cheeses, e.g., parmesan, cheddar Beverages o All tap beer, and other non-pasteurized beer Other o Concentrated yeast extract; Sauerkraut; Most soy products including soy sauce and tofu; and OTC supplements containing tyramine Medications which increase the risk of serotonin syndrome or hypertensive crisis Antidepressants o SSRIs - citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline o SNRIs - duloxetine, venlafaxine o Tricyclic, e.g., amitriptyline, imipramine, desipramine, nortriptyline, clomipramine, doxepin o Mirtazapine o Bupropion o Other MAOIs (isocarboxazid, phenelzine, tranylcypromine, selegiline) o St. John's Wort Analgesics o Meperidine; tramadol; methadone; propoxyphene Anticonvulsants o Carbamazepin[Wed Nov 10 16:18:04 2010] dofile.pl: Wide character in print at c:\inetpub\wwwroot\reports \dofile.pl line 96. e; Oxcarbazepine Stimulants, including amphetamines Cough/Cold Products containing o Dextromethorphan o Decongestants, e.g., pseudoephedrine, phenylephrine Buspirone Cyclobenzaprine August 2007 VISN 20 P&T Committee	
CN301	PHENOBARBITAL 15MG, 30MG, 100MG TAB	LUMINAL	Open Formulary - no restrictions	FORMULARY
CN301	PHENOBARBITAL ELIXIR 20MG/5ML	LUMINAL	Open Formulary - no restrictions	FORMULARY
CN301	PHENOBARBITAL INJ 130MG 1ML	LUMINAL	Open Formulary - no restrictions	FORMULARY
NT300	PHENOL ORAL LIQUID	N/A	Open Formulary - no restrictions	FORMULARY
PH000	PHENOL TOPICAL LIQUID	N/A	Open Formulary - no restrictions	FORMULARY
AU200	PHENOXYBENZAMINE HCL ORAL	DIBENZYLINE	Open Formulary - no restrictions	FORMULARY
AU200	PHENTOLAMINE MESYLATE INJ	REGITINE	Open Formulary - no restrictions	FORMULARY
NT100	PHENYLEPHRINE HCL NASAL SPRAY (OTC)	NEO-SYNEPHRINE	Open Formulary - no restrictions	FORMULARY
AU100	PHENYLEPHRINE INJ 1%	NEO-SYNEPHRINE	Open Formulary - no restrictions	FORMULARY
OP600	PHENYLEPHRINE OPHTH SOLN	NEO-SYNEPHRINE	Open Formulary - no restrictions	FORMULARY

CN400	PHENYTOIN (DILANTIN) 125MG/5ML	DILANTIN	Open Formulary - no restrictions	FORMULARY
CN400	PHENYTOIN 50MG CHEW TAB	DILANTIN	Open Formulary - no restrictions	FORMULARY
CN400	PHENYTOIN INJ 50MG/ML 2ML	DILANTIN	Open Formulary - no restrictions	FORMULARY
CN400	PHENYTOIN NA (DILANTIN) 100MG CAP	DILANTIN	Open Formulary - no restrictions	FORMULARY
CN400	PHENYTOIN NA (DILANTIN) 30MG CAP	DILANTIN	Open Formulary - no restrictions	FORMULARY
RS300	PHOSPHATES ENEMA (0TC)	FLEETS PHOSPHATE ENEMA	Open Formulary - no restrictions	FORMULARY
TN408	PHOSPHORUS/POTASSIUM PWDR	NEUTRA-PHOS	Open Formulary - no restrictions	FORMULARY
AU300	PHYSOSTIGMINE INJ 1MG/ML	ANTILIRIUM	Open Formulary - no restrictions	FORMULARY
VT702	PHYTONADIONE 5MG TAB	MEPHYTON	Open Formulary - no restrictions	FORMULARY
VT702	PHYTONADIONE INJ 10MG/ML	AQUAMEPHYTON	Open Formulary - no restrictions	FORMULARY
OP102	PILOCARPINE 1% OPHTH SOLN 15ML	ISOPTO CARPINE	Open Formulary - no restrictions	FORMULARY
OP102	PILOCARPINE 2% OPHTH SOLN 15ML	ISOPTO CARPINE	Open Formulary - no restrictions	FORMULARY
OP102	PILOCARPINE 3% OPHTH SOLN 15ML	ISOPTO CARPINE	Open Formulary - no restrictions	FORMULARY
OP102	PILOCARPINE 4% OPHTH SOLN 15ML	ISOPTO CARPINE	Open Formulary - no restrictions	FORMULARY
OP102	PILOCARPINE HCL OPH GEL	PILOPINE HS	Open Formulary - no restrictions	FORMULARY
AU300	PILOCARPINE HCL ORAL	SALAGEN	Open Formulary - no restrictions	FORMULARY
CN900	PIMOZIDE ORAL	ORAP	Restricted to Psychiatry/Mental Health or local equivalent	FORMULARY
AM054	PIPERACILLIN NA INJ	PIPRACIL	Open Formulary - no restrictions	FORMULARY
AM054	PIPERACILLIN NA/TAZOBACTAM INJ	ZOSYN	Restrictions per local facility	FORMULARY
MS102	PIROXICAM ORAL	FELDENE	Open Formulary - no restrictions	FORMULARY
BL500	PLASMA PROTEIN FRACTION 5% INJ	N/A	Restrictions per local facility	FORMULARY
XA514	PLUG CATHETER	N/A	Open Formulary - no restrictions	FORMULARY
IM100	PNEUMOCOCCAL VACCINE 0.5ML INJ	PNEOMOVAX	Open Formulary - no restrictions	FORMULARY
DE500	PODOFILOX 0.5% TOP SOLN	CONDYLOX	Open Formulary - no restrictions	FORMULARY
DE500	PODOPHYLLUM RESIN 25%/BENZOIN TOP TINCTURE	PODODERM	Podophyllum resin should not be dispensed to outpatients for self-administration as it requires administration by a healthcare provider. November 2003	FORMULARY
IM100	POLIOVIRUS VACCINE INACTIVATED	N/A	Open Formulary - no restrictions	FORMULARY
GA202	POLYETHYLENE GLYCOL 3350 WITHOUT ELECTROLYTES	MIRALAX	Open Formulary - no restrictions	FORMULARY

AM900	POLYMYXIN B SO4 INJ	AEROSPORIN	Restrictions per local facility	FORMULARY
OP209	POLYMYXIN B/TRIMETHOPRIM OPH SOLN	POLYTRIM	Restricted to prescriptions by Eye Clinic staff or local facility equivalent only if other agents are contraindicated or ineffective.	FORMULARY
AN900	PORFIMER INJ	PHOTOFRIN	Restricted to Hematology/Oncology, GI, or local facility equivalent. FDA indications include Barrett???s esophagus in patients not undergoing esophagectomy, esophageal cancer, early stage non-small cell lung cancer in patients not candidates for surgery and radiotherapy. Sept 2006	FORMULARY
TN403	POTASSIUM ACETATE INJ 40MEQ/20ML	N/A	Open Formulary - no restrictions	FORMULARY
TN430	POTASSIUM BICARBONATE EFFERVESCENT TAB	N/A	Open Formulary - no restrictions	FORMULARY
TN403	POTASSIUM CHLORIDE 20MEQ/PKT ORAL	N/A	Open Formulary - no restrictions	FORMULARY
TN403	POTASSIUM CHLORIDE 8MEQ, 10MEQ SA TAB	K-DUR	Open Formulary - no restrictions	FORMULARY
TN403	POTASSIUM CHLORIDE INJ	N/A	Open Formulary - no restrictions	FORMULARY
TN102	POTASSIUM CHLORIDE INJ (IN TN403)	N/A	Open Formulary - no restrictions	FORMULARY
TN478	POTASSIUM CITRATE TAB, SA	N/A	Open Formulary - no restrictions	FORMULARY
RE302	POTASSIUM IODIDE SOLN	N/A	Open Formulary - no restrictions	FORMULARY
TN408	POTASSIUM PHOSPHATE INJ	N/A	Restrictions per local facility	FORMULARY
XA403	POUCH CLOSED ONE-PIECE W/ADHESIVE	N/A	Open Formulary - no restrictions	FORMULARY
XA404	POUCH CLOSED TWO-PIECE W/O ADHESIVE FLANGE SIZE 1	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH DRAINABLE 2-PC W/O ADHESIVE UROST FLANGE SZ	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH DRAINABLE ONE PIECE CUSTOM-CUT W/ADHESIVE	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH DRAINABLE TWO- PIECE W/O ADHESIVE FLANGE SIZ	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH DRAINABLE W/ADHESIVE UROSTOMY	N/A	Open Formulary - no restrictions	FORMULARY
XA599	POUCH RETRACTED PENIS	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,CENTER POINT LOCK H#3812 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,CENTER POINT LOCK H#3813 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY

XA402	POUCH,DRAINABLE,CENTER POINT LOCK H#3817 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,FIRSTCHOICE H#3614 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,FIRSTCHOICE H#3616 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,FIRSTCHOICE H#3618 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,FIRSTCHOICE H#3619 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,FIRSTCHOICE H#3631 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,FIRSTCHOICE H#3675 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,KARAYA SEAL H#3223 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,KARAYA SEAL H#3224 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,KARAYA SEAL H#3225 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,KARAYA SEAL H#3228 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,KARAYA SEAL H#3229 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,PREMIUM H#3663 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,PREMIUM H#3664 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,PREMIUM H#3668 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA401	POUCH,DRAINABLE,PREMIUM H#3669 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,SUR-FIT C#0256-30 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,SUR-FIT C#0256-31 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,SUR-FIT C#0256-32 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,SUR-FIT C#0256-33 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,SUR-FIT C#0256-40 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,SUR-FIT C#0256-41 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,SUR-FIT C#0256-42 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,DRAINABLE,SUR-FIT C#0256-43 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY

XA403	POUCH,MINI,CLOSED,FILTER H#3144 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA404	POUCH,MINI,CLOSED,SUR-FIT C#0257-77 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY H#3802 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY H#3803 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY H#3804 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY H#3806 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY H#3807 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY H#3814 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY,ACTIVE LIFE C#0227-71 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY,ACTIVE LIFE C#1757-78 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY,ACTIVE LIFE C#1757-79 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA402	POUCH,OSTOMY,ACTIVE LIFE C#1757-80 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY H#3902 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY H#3903 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY W/ACCUSEAL C#0219-26 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY W/ACCUSEAL C#0219-27 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY W/ACCUSEAL C#0219-28 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY W/ACCUSEAL C#0219-29 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY W/ACCUSEAL C#0219-36 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY W/ACCUSEAL C#0219-37 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY W/ACCUSEAL C#0219-38 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA505	POUCH,UROSTOMY W/ACCUSEAL C#0219-39 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH,UROSTOMY,ACTIVE LIFE C#1757-92 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH,UROSTOMY,ACTIVE LIFE C#1757-93 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY

XA504	POUCH,UROSTOMY,ACTIVE LIFE C#1757-94 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH,UROSTOMY,ACTIVE LIFE C#1757-96 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH,UROSTOMY,ACTIVE LIFE C#1757-98 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH,UROSTOMY,FIRSTCHOICE H#1482 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH,UROSTOMY,FIRSTCHOICE H#1483 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH,UROSTOMY,FIRSTCHOICE H#1484 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH,UROSTOMY,FIRSTCHOICE H#1486 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA504	POUCH,UROSTOMY,FIRSTCHOICE H#1488 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE101	POVIDONE IODINE 1% TOP OINT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE101	POVIDONE IODINE 10% OINTMENT 30 GM	N/A	Open Formulary - no restrictions	FORMULARY
XA105	POVIDONE IODINE 10% PAD	N/A	Open Formulary - no restrictions	FORMULARY
DE101	POVIDONE IODINE 10% PREP PAD (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE400	POVIDONE IODINE 10% SWABSTICK (OTC)	BETADINE SWABSTICKS	Open Formulary - no restrictions	FORMULARY
DE101	POVIDONE IODINE 10% TOPICAL SOL	BETADINE	Open Formulary - no restrictions	FORMULARY
DE101	POVIDONE IODINE 7.5% SURGICAL SCRUB (OTC)	BETADINE SCRUB	Open Formulary - no restrictions	FORMULARY
OP210	POVIDONE IODINE OPHTHALMIC SOLUTION	N/A	Open Formulary - no restrictions	FORMULARY
XA604	POWDER,STOMAHESIVE (OTC)	STOMAHESIVE	Open Formulary - no restrictions	FORMULARY
AD900	PRALIDOXIME CL INJ	PROTOPAM	Open Formulary - no restrictions	FORMULARY
DE700	PRAMOXINE HCL 1% CREAM (OTC)	TRONOLANE	Open Formulary - no restrictions	FORMULARY
DE700	PRAMOXINE HCL 1% LOTION (OTC)	PRAX	Open Formulary - no restrictions	FORMULARY
CV350	PRAVASTATIN ORAL TABS	PRAVACHOL	Simvastatin is the first line statin. Pravastatin is the preferred second line statin. Pravastatin and lovastatin are restricted to patients who cannot take simvastatin due to intolerance or drug interactions. Pharmacists have the authority to automatically convert prescriptions for lovastatin to simvastatin on a 2:1 (mg:mg) basis and lovastatin to pravastatin on a 1:1 (mg:mg) basis for patients unable to take simvastatin. September 2007, November 2008 VISN 20 P&T Committee	FORMULARY
CV150	PRAZOSIN HCL 1MG, 2MG, 5MG CAP	MINIPRES	Open Formulary - no restrictions	FORMULARY

OP300	PREDNISOLONE OPH SUSP	PRED FORTE	Open Formulary - no restrictions	FORMULARY
OP350	PREDNISOLONE/SULFACETAMIDE OPH SOLN	METIMYD	Open Formulary - no restrictions	FORMULARY
HS051	PREDNISONE 20MG, 50MG TAB	DELTASONE	Open Formulary - no restrictions	FORMULARY
HS051	PREDNISONE 5MG, 10MG TAB	DELTASONE	Open Formulary - no restrictions	FORMULARY
VT802	PRENATAL VITAMINS	N/A	Restricted to female patients.	FORMULARY
CN204	PRILOCAINE HCL/EPINEPHRINE INJ	N/A	Open Formulary - no restrictions	FORMULARY
CN204	PRILOCAINE INJ	CITANEST	Open Formulary - no restrictions	FORMULARY
AP101	PRIMAQUINE PHOSPHATE ORAL	N/A	Open Formulary - no restrictions	FORMULARY
CN400	PRIMIDONE ORAL	MYSOLINE	Open Formulary - no restrictions	FORMULARY
MS400	PROBENECID 500MG TAB	BENEMID	Open Formulary - no restrictions	FORMULARY
CV300	PROCAINAMIDE INJ 100MG/ML 10ML	N/A	Open Formulary - no restrictions	FORMULARY
CN204	PROCAINE HCL INJ	NOVOCAINE	Open Formulary - no restrictions	FORMULARY
AN900	PROCARBAZINE ORAL	MATULANE	Restricted to Oncology Service or local equivalent	FORMULARY
GA700	PROCHLORPERAZINE 25MG RTL SUPP	COMPAZINE	Open Formulary - no restrictions	FORMULARY
GA700	PROCHLORPERAZINE INJ 10MG/2ML	COMPAZINE	Open Formulary - no restrictions	FORMULARY
GA700	PROCHLORPERAZINE MALEATE 10MG TAB	COMPAZINE	Open Formulary - no restrictions	FORMULARY
AH100	PROMETHAZINE HCL ORAL	PHENERGAN	Open Formulary - no restrictions	FORMULARY
AH100	PROMETHAZINE HCL RTL SUPP	PHENERGAN	Open Formulary - no restrictions	FORMULARY
AH100	PROMETHAZINE INJ	PHENERGAN	Open Formulary - no restrictions	FORMULARY
CV300	PROPAFENONE HCL ORAL IR TABLET	RYTHMOL	Initial prescriptions must be approved by Cardiology with documentation of the indication and treatment goals. Renewals require an annual Cardiology review. July 2009	FORMULARY
AU350	PROPANTHELINE BROMIDE 7.5MG, 15MG TAB	PROBANTHINE	Open Formulary - no restrictions	FORMULARY
OP700	PROPARACAINE 0.5% OPHTH SOLUTION	OPHTHAINE	Open Formulary - no restrictions	FORMULARY
CN203	PROPOFOL INJ	DIPRIVAN	Restrictions per local facility	FORMULARY
CV100	PROPRANOLOL 10, 20, 40, 80MG TAB	INDERAL	Open Formulary - no restrictions	FORMULARY
CV100	PROPRANOLOL HCL CAP, SA	INDERAL	Restricted to Migraine Prophylaxis only. Sept 2006	FORMULARY
PH000	PROPYLENE GLYCOL LIQUID	N/A	Open Formulary - no restrictions	FORMULARY
HS852	PROPYLTHIOURACIL ORAL	N/A	Open Formulary - no restrictions	FORMULARY
BL200	PROTAMINE SULFATE 10MG/ML 5ML INJ	N/A	Restrictions per local facility	FORMULARY

DX900	PROTIRELIN INJ	THYREL	Open Formulary - no restrictions	FORMULARY
RE501	PSEUDOEPHEDRINE 60MG/TRIPROLIDINE 2.5MG TAB (OTC)	ACTIFED	All products containing pseudoephedrine are restricted to a 30 day supply, not to exceed a quantity of 100 tablets and a maximum of 5 refills. Nonworking stock of pseudoephedrine must be stored in a secure area in the pharmacy. January 2006, June 2006 VISN 20 P&T Committee	FORMULARY
RE200	PSEUDOEPHEDRINE HCL ORAL TAB	SUDAFED	All products containing pseudoephedrine are restricted to a 30 day supply, not to exceed a quantity of 100 tablets and a maximum of 5 refills. Nonworking stock of pseudoephedrine must be stored in a secure area in the pharmacy. January 2006, June 2006 VISN 20 P&T Committee	FORMULARY
GA201	PSYLLIUM ORAL PWD SUGAR FREE	KONSYL	Open Formulary - no restrictions	FORMULARY
GA201	PSYLLIUM ORAL PWDR (OTC)	METAMUCIL	Open Formulary - no restrictions	FORMULARY
AM500	PYRAZINAMIDE 500MG TAB	N/A	Open Formulary - no restrictions	FORMULARY
AU300	PYRIDOSTIGMINE 5MG/ML INJ	REGONOL	Open Formulary - no restrictions	FORMULARY
AU300	PYRIDOSTIGMINE BROMIDE 180MG SA	MESTINON TIMESPAN	Open Formulary - no restrictions	FORMULARY
AU300	PYRIDOSTIGMINE BROMIDE 60MG TAB	N/A	Open Formulary - no restrictions	FORMULARY
VT104	PYRIDOXINE HCL 50MG TAB	VITAMIN B-6	Open Formulary - no restrictions	FORMULARY
VT104	PYRIDOXINE HCL INJ	VITAMIN B-6	Open Formulary - no restrictions	FORMULARY
AP101	PYRIMETHAMINE ORAL	DARAPRIM	Open Formulary - no restrictions	FORMULARY
CN709	QUETIAPINE ORAL	SEROQUEL	VISN 20 Guidelines for Atypical Antipsychotics Atypical antipsychotics are restricted to the treatment of first episode psychosis or chronic psychosis in relapse. (national guidelines) First (and 2nd) line atypical antipsychotics: (alphabetical, no prescribed hierarchy) Aripiprazole Quetiapine Risperidone Ziprasidone 3rd line Olanzapine Clozapine (if poor response to AT LEAST 2 other	FORMULARY

atypical antipchotics)

April 2007 VISN 20 P&T Committee

VISN 20 Guidelines for
Screening and Monitoring Patients Prescribed Atypical Antipsychotics

Baseline Screening Guidelines

Prior to initiating a new atypical antipsychotic, it is recommended that
clinicians:

1. Obtain/review the patient's personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease.

2. Provide basic education about signs and symptoms of
Hyperglycemia
Diabetic ketoacidosis

3. Obtain or document in CPRS baseline measures for
Fasting lipid panel and fasting blood sugar (or an HgA1C if it is difficult to get the patient's cooperation for a fasting blood sugar)
Weight (entered into CPRS Cover Sheet)
Height (entered into CPRS Cover Sheet)
Blood pressure (entered into CPRS Cover Sheet)

Subsequent Monitoring Guidelines

During the first 4 months of treatment, it is recommended that clinicians:

1. Obtain a fasting blood sugar and lipid panel at least once.
2. Record weight at each visit; note any increases.
3. Record blood pressure at least once.

At one year of treatment, it is recommended that clinicians:

1. Make sure that a recent weight and blood

			pressure are recorded in the chart. 2. Repeat fasting glucose. 3. Order a lipid panel if there are concerns about significant weight gain, personal or family risk factors for cardiovascular disease, or past abnormal laboratory results. After one year, monitoring is at the clinician's discretion. Considerations that would warrant further annual or more frequent screening include: 1. Significant amount of weight gain or pre-existing obesity 2. Family or personal history of other significant risk factors for cardiovascular disease or diabetes 3. Past abnormal laboratory screening results Summary of VISN 20 Screening and Monitoring Recommendations Measure Baseline First 4 Months One Year Personal/Family History Yes Review any changes Patient/Family Education Yes Height Yes Weight (BMI) Yes Each visit Yes Fasting glucose/ Hgb A1c Yes At least once Yes Fasting lipid profile Yes At least once If clinically indicated Blood pressure Yes At least once Yes June 2005 VISN 20 P&T	
CV300	QUINIDINE GLUCONATE 324MG SA TAB	QUINAGLUTE	Open Formulary - no restrictions	FORMULARY
CV300	QUINIDINE SULFATE 200MG TAB	N/A	Open Formulary - no restrictions	FORMULARY
AM900	QUINUPRISTIN/DALFOPRISTIN		FORMULARY, RESTRICTED TO CLINICAL RECOMMENDATION	FORMULARY
IM500	RABIES IMMUNE GLOBULIN,HUMAN	N/A	Open Formulary - no restrictions	FORMULARY

IM100	RABIES VACCINE, HUMAN DIPLOID	N/A	Open Formulary - no restrictions	FORMULARY
DE900	RADIAPLEX TOPICAL GEL	RADIAPLEX	Restricted to radiation oncology	FORMULARY
AM800	RALTEGRAVIR ORAL TAB	ISENTRESS	PBM/MAP National Criteria for Use: Raltegravir (12/2007) FDA APPROVED INDICATION FOR USE Raltegravir is indicated in combination with other antiretroviral agents for treatment of HIV-1 in treatment-experienced adult patients who have evidence of viral replication and HIV-1strains resistant to multiple antiretroviral agents. EXCLUSION CRITERION (If selected, patient is NOT eligible) - HIV-2 INCLUSION CRITERIA (All must be selected for patient to be eligible) - Treatment-experienced patient (defined as 3 class experience with at least one protease inhibitor failure) - Evidence of virologic failure (documented by a viral load >1,000 copies/mL) or intolerant to an individual agent within current antiretroviral regimen - Able to construct a multi-drug regimen that includes, preferably, at least one additional active antiretroviral drug (if available) in addition to raltegravir - Under the care of an experienced HIV practitioner DOSAGE AND ADMINISTRATION (Refer to PI for dosage recommendations in organ dysfunction) 400mg orally twice daily without regard to food. RECOMMENDED MONITORING In addition to standard monitoring in a patient receiving antiretrovirals, the following is recommended: 1) Baseline and periodic monitoring of LFTs, particularly in patients with pre-existing liver dysfunction or co-infected with viral hepatitis B or C. 2) Baseline and periodic monitoring of CPK, particularly in patients receiving other medications associated with elevations of CPK. - Because of the risk of myopathy or rhabdomyolysis, caution should be used when prescribing raltegravir with other medications that can cause these conditions. - Potential risk for malignancy ISSUES FOR CONSIDERATION Caution should be used when co-administering raltegravir with inducers of UGT1A1 (e.g., rifampin, phenytoin, phenobarbital) due to reduced plasma concentrations of raltegravir. VISN 20 P&T Feb 2008	FORMULARY
OP900	RANIBIZUMAB OPHTH INJECTION	LUCENTIS	Ranibizumab is restricted to Ophthalmology and retinal specialists for patients with the approved indication of wet AMD. January 2007 VISN 20 P&T Committee	FORMULARY
GA301	RANITIDINE 15OMG, 300MG TAB	ZANTAC	Open Formulary - no restrictions	FORMULARY
GA301	RANITIDINE INJ	ZANTAC	Open Formulary - no restrictions	FORMULARY

CN500	RASAGILINE	AZILECT	FORMULARY,CFU RESTRICTED TO NEUROLOGY	FORMULARY
CN101	REMIFENTANYL INJ	ULTIVA	Restrictions per local facility	FORMULARY
VT801	RENAL MULTIVITAMIN W =/< 1 MG FOLIC ACID	DIALYVITE	Restricted to dialysis patients.	FORMULARY
CV490	RESERPINE 0.1MG TAB	SERPASIL	Open Formulary - no restrictions	FORMULARY
CV490	RESERPINE 0.25MG TAB	SERPASIL	Open Formulary - no restrictions	FORMULARY
BL600	RETEPLASE INJ	RETEVASE	Reteplase (Retevase) is formulary, restricted to vascular surgery and interventional radiology for thrombolysis of acute peripheral vascular occlusions. Sept 2006 VISN 20 P&T	FORMULARY
AM800	RIBAVIRIN ORAL CAP	REBETOL	Restricted to Infectious Diseases, Gastroenterology, Liver Transplant, and/or Hepatology Services or local facility equivalent. October 2001	FORMULARY
AM800	RIBAVIRIN/INTERFERON ALPHA 2B INJ	REBETRON	Restricted to Infectious Disease, Gastroenterology, Liver Transplant and/or hepatology or local facility equivalents. November 1998	FORMULARY
AM900	RIFABUTIN ORAL	MYCOBUTIN	Restricted to ID Service or local equivalent	FORMULARY
AM500	RIFAMPIN 300MG CAP	RIMACTANE	Open Formulary - no restrictions	FORMULARY
AM500	RIFAMPIN INJ	RIMACTANE	Open Formulary - no restrictions	FORMULARY
AM800	RIMANTADINE HCL ORAL TAB	FLUMADINE	Criteria for Use of Antiviral Agents for Influenza December 2009 VHA Pharmacy Benefits Management Service and the Medical Advisory Panel VA RECOMMENDATION FOR CHEMOPROPHYLAXIS AND TREATMENT OF 2009 H1N1 AND SEASONAL INFLUENZA Recommendations for 2009 H1N1 and seasonal influenza are dynamic; recommendations for use of antiviral medications may change as data on antiviral effectiveness, clinical spectrum of illness, adverse events from antiviral use, or resistance among circulating viruses become available. Providers and local facilities will need to coordinate implementation of these guidelines with any updated CDC and/or local health department recommendations. Chemoprophylaxis for Influenza Based upon CDC interim recommendations for antiviral chemoprophylaxis, the VA recommends oseltamivir or zanamivir be considered in persons exposed to 2009 H1N1 or seasonal influenza as described below. Persons who are at higher risk for complications of influenza (including pregnant women) and are an unprotected close contact of a person with confirmed, probable, or suspected 2009 H1N1 or seasonal	FORMULARY

influenza during that person's infectious period. Health care personnel, public health workers, or first responders who have had a recognized, unprotected close contact exposure to a person with confirmed, probable, or suspected 2009 H1N1 or seasonal influenza during that person's infectious period. Chemoprophylaxis of healthcare workers should be prescribed in consultation with occupational health Antiviral agents should NOT be used for post exposure chemoprophylaxis in healthy children or adults based on potential exposures in the community, school, camp or other settings. Chemoprophylaxis generally is not recommended if more than 48 hours have elapsed since the last contact with an infectious person. Chemoprophylaxis is not indicated when contact occurred before or after, the ill person's infectious period. Outbreaks in Nursing Homes When 2009 H1N1 outbreaks occur, it is recommended that ill patients be treated with oseltamivir or zanamivir and that chemoprophylaxis with either oseltamivir or zanamivir be started as early as possible to reduce the spread of the virus as is recommended for seasonal influenza outbreaks in such settings. Outbreaks of seasonal influenza may be more likely in nursing homes and may require chemoprophylaxis with oseltamivir and/or an olchicine depending on whether the outbreak were due to seasonal H1N1 (resistant to oseltamivir) or to seasonal H3N2 or influenza B (both of which are resistant to the adamantanes). If the type of seasonal influenza is not known, chemoprophylaxis should consist of oseltamivir plus an olchicine. Treatment for Influenza As of December 4, 2009, 99% of circulating influenza viruses were 2009 H1N1 viruses susceptible to both oseltamivir and zanamivir. The CDC (and VA) treatment recommendations therefore focus on use of antiviral medications effective against 2009 H1N1 viruses. Based upon the CDC recommendations for antiviral treatment, the VA recommends oseltamivir or zanamivir should be used in patients with confirmed, probable or suspected 2009 H1N1 or seasonal influenza and one of the following: Illness requiring hospitalization Progressive, severe, or complicated illness, regardless of previous health status Patients at risk for severe disease Other treatment considerations: Once the decision to administer antiviral treatment is made by the health care provider, treatment with zanamivir or oseltamivir should be initiated as soon as possible even before definitive diagnostic test results

			become available (i.e., treatment should not wait for laboratory confirmation of influenza). Evidence for benefits from antiviral treatment in studies of uncomplicated seasonal influenza is strongest when treatment is started within 48 hours of illness onset. Initiating treatment as soon as possible after illness onset is also thought likely to reduce the risk of severe outcomes including severe illness or death. However, some studies of hospitalized patients with seasonal influenza treated with oseltamivir have suggested benefit, including reductions in mortality or duration of hospitalization, even for patients whose treatment was started more than 48 hours after illness onset. Clinicians should consider the possibility of bacterial coinfections that can occur during or after an influenza illness. In October 2009, monovalent inactivated and live attenuated 2009 H1N1 influenza vaccines became available in the United States. Although these vaccines are expected to be highly effective, no vaccine is 100% effective. Therefore, a history of receipt of 2009 H1N1 or seasonal influenza vaccine does not rule out influenza infection. Early empiric treatment should be initiated for vaccinated persons with suspected influenza infection when indicated (e.g. persons requiring hospitalization, with severe infection, or at higher risk for influenza-related complications). Vaccination with 2009 H1N1 influenza vaccine is not expected to provide protection against infection with seasonal influenza A or B viruses. Similarly, vaccination with seasonal influenza vaccine is not expected to prevent infection with 2009 H1N1 influenza virus. Intravenous Peramivir has been authorized for use by the FDA, subject to the Emergency Use Authorization (EUA) terms and conditions. Specifically, peramivir is authorized for the following patients who are admitted to a hospital: Adult patients for whom therapy with an IV agent is clinically appropriate, based upon one or more of the following reasons: o patient not responding to either oral or inhaled antiviral therapy, or o drug delivery by a route other than IV (e.g. enteral oseltamivir or inhaled zanamivir) is not expected to be dependable or is not feasible, or o the clinician judges IV therapy is appropriate due to other circumstances. Pediatric patients for whom an IV agent is clinically appropriate because: o patient not responding to either oral or inhaled antiviral therapy, or o drug delivery by a route other than IV (e.g. enteral oseltamivir or inhaled zanamivir) is not expected to be

			dependable or is not feasible To request peramivir under the EUA for a specific patient, the request process can be initiated via http://www.cdc.gov/h1n1flu/eua/peramivir.htm Treatment of influenza when oseltamivir-resistant viruses are circulating Oseltamivir resistance is common among seasonal influenza A (H1N1) viruses. These seasonal H1N1 viruses typically remain susceptible to rimantadine and amantadine. However, since April 2009, very few seasonal H1N1 viruses have circulated in the United States. Therefore, treatment, when indicated, with either oseltamivir or zanamivir is appropriate. However, if viral surveillance data indicate that oseltamivir-resistant seasonal H1N1 viruses have become more common or are associated with identified community outbreaks, zanamivir or a combination of oseltamivir and rimantadine or amantadine should be considered for use as empiric treatment for patients who might have oseltamivir-resistant seasonal human influenza A (H1N1) virus infection. Table 1. Definitions for Influenza Infection Influenza-like-illness (ILI) is defined as fever (temperature of 100F [37.8C] or greater) and a cough and/or a sore throat in the absence of a KNOWN cause other than influenza. Infectious period for a confirmed case of influenza virus infection is defined as 1 day prior to the case's illness onset to 7 days after onset. Close contact is defined as having cared for or lived with a person who is a confirmed, probable or suspected case of influenza, or having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of such a person. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, physical examination, or any other contact between persons likely to result in exposure to respiratory droplets. Table 2. Definition of High-Risk Groups for 2009 Influenza (H1N1) and Seasonal Influenza High-risk groups: A person who is at high-risk for complications of 2009 H1N1 virus infection is defined as the same for seasonal influenza at this time. Adults 65 years of age and older. Persons with the following conditions: o Chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological (including sickle cell disease), neurologic, neuromuscular, or metabolic disorders (including diabetes mellitus); o Immunosuppression, including that caused by medications or by HIV; o Pregnant women**; o Persons younger than 19 years

			of age who are receiving long-term aspirin therapy; o Residents of nursing homes and other chronic-care facilities. Children younger than 5 years old. The risk for severe complications from seasonal influenza is highest among children younger than 2 years old. Preliminary studies suggest that people who are morbidly obese (body mass index equal to or greater than 40) and perhaps people who are obese (body mass index 30 to 39) may be at increased risk of hospitalization and death due to 2009 H1N1 influenza infection. Additional studies to determine the risk of morbid obesity and /or obesity for these complications of 2009 H1N1 virus infection are underway. Patients with morbid obesity, and perhaps obesity, often have underlying conditions that put them at increased risk for complications due to 2009 H1N1 influenza infection, such as diabetes, asthma, chronic respiratory illness or liver disease. ** Refer to consideration in pregnant women for further discussion Consideration in Pregnant Women Pregnant women are known to be at higher risk for complications from infection with seasonal influenza viruses, and severe disease among pregnant women was reported during past pandemics. Hospitalizations and deaths have been reported among pregnant women with 2009 H1N1 influenza virus infection, and one study estimated that the risk for hospitalization for 2009 H1N1 influenza was four times higher for pregnant women than for the general population. While oseltamivir and zanamivir are Pregnancy Category C medications, indicating that no clinical studies have been conducted to assess the safety of these medications for pregnant women, the available risk-benefit data indicate pregnant women with suspected or confirmed influenza should receive prompt antiviral therapy. Pregnancy should not be considered a contraindication to oseltamivir or zanamivir use. Because of its systemic activity, oseltamivir is preferred for treatment of pregnant women. The drug of choice for chemoprophylaxis is less clear. Zanamivir may be preferable because of its limited systemic absorption; however, respiratory complications that may be associated with zanamivir because of its inhaled route of administration need to be considered, especially in women at risk for respiratory problems. . . Table 3: Recommended Daily Adult Dosages of Novel Influenza (2009 HIN1) and Seasonal Influenza Antiviral Medications for Treatment and Chemoprophylaxis Antiviral Agent: Zanamivir Treatment, influenza A and B

			18-64 yrs old 10 mg (2 inhalations) twice daily for 5 days 65 and older 10 mg (2 inhalations) twice daily for 5 days Renal and Hepatic dysfunction No dosage reduction is recommended for patients with mild, moderate and severe renal impairment. However, the potential for drug accumulation should be considered in patients with severe renal insufficiency. Zanamivir has not been studied in patients with liver disease. Prophylaxis, influenza A and B 18-64 yrs old 10 mg (2 inhalations) once daily for 10 days 65 and older 10 mg (2 inhalations) once daily for 10 days Antiviral Agent: Oseltamivir Treatment, influenza A and B 18-64 yrs old 75 mg twice daily for 5 days 65 and older 75 mg twice daily for 5 days Renal and Hepatic dysfunction CrCl 10-30 ml/min: 75 mg once daily CAPDc: 30 mg once weekly Hemodialysis (note c): 30 mg after every other session Oseltamivir has not been studied in patients with liver disease. Prophylaxis, influenza A and B 18-64 yrs old 75 mg once daily for 10 daysa 65 and older 75 mg once daily for 10 daysa Renal and Hepatic dysfunction CrCl 10 - 30 ml/min: 75 mg every other day or 30 mg once daily Antiviral Agent: Amantadine Treatment, influenza A 18-64 yrs old 100 mg twice daily for 5 days 65 and older 100 mg/day for 5 days Renal and Hepatic dysfunction CrCl	
OP300	RIMEXOLONE 1% OPH SUSP	VEXOL	Reserved for long-term therapy. February 1998	FORMULARY
TN102	RINGER'S INJ	N/A	Open Formulary - no restrictions	FORMULARY
IR100	RINGER'S IRRG SOLN	N/A	Open Formulary - no restrictions	FORMULARY
HS900	RISEDRONATE ORAL	ACTONEL	Formulary, second line after alendronate, reserved for patients who are intolerant to or have an inadequate response to alendronate therapy. February 2001, April 2004	FORMULARY
CN709	RISPERIDONE MICROSPHERES FOR INJECTION	RISPERDAL CONSTA	VISN 20 Risperidone Microspheres for Injection (Risperdal Consta) Guidelines Risperidone Microspheres for Injection is formulary, restricted to the following guidelines: Treatment Criteria: to be started on Risperidone Microspheres for Injection a patient must have all the following five elements: 1. A diagnosis of Schizophrenia or Schizoaffective Disorder by DSM IV criteria. 2. A prescriber who is a provider in the Mental Health Service Line or local equivalent. 3. A history of tolerating oral risperidone without significant side effects. 4. Demonstrated need for a depot antipsychotic due to persistent noncompliance with oral medications resulting in clinical instability, as evidenced	FORMULARY

			by any one of the following: a. Repeated significant behavioral problems due to symptoms of psychosis. b. Repeated psychiatric hospitalizations. c. Prolonged psychiatric hospitalizations. 5. Documented clinical evidence of inappropriateness for treatment with haloperidol or fluphenazine decanoate due to either of the following: a. Currently being treated with haloperidol or fluphenazine decanoate with at least one of the following being present: (1) Significant tardive dyskinesia as measured by the AIMS. (2) Significant EPS or other adverse effects that are not responsive to treatment. (3) Significant symptoms of psychosis that cause ongoing problems for the patient???s behavior or functional ability despite treatment with adequate decanoate doses. b. Should not be started on haloperidol or fluphenazine decanoate due to one of the following: (1) Documented presence of significant tardive dyskinesia as measured by the AIMS. (2) Documented past lack of response of psychotic symptoms to haloperidol and fluphenazine in oral or decanoate form. (3) Past significant adverse reactions to haloperidol and fluphenazine in their oral or decanoate forms. (4) Allergy to the sesame oil used in the decanoate formulations. (5) Excellent past clinical response to oral risperidone. Exclusion Criteria: patients are not appropriate for treatment with Risperidone Microspheres for Injection if either of the following is present: 1. Currently clinically stable on haloperidol decanoate or fluphenazine decanoate without significant side effects. 2. Previously documented development of significant side effects or lack of clinical efficacy with oral risperidone. Other Guidelines: 1. Patients who are started on Risperidone Microspheres for Injection by non VA providers and are referred for continuing treatment should be evaluated for past medication response history, reasons for Risperidone Microspheres for Injection use, and current response to Risperidone Microspheres for Injection so that a clinical decision can be made about the appropriateness of continuation. 2. After starting Risperidone Microspheres for Injection, patients should be tapered off oral antipsychotics once stable. Supplemental doses of oral risperidone may be helpful for break through symptoms, but the use of other additional oral atypicals in combination with Risperidone Microspheres for Injection should be avoided. September 17, 2004	

CN709	RISPERIDONE ORAL SOLUTION 1MG/ML	RISPERDAL	VISN 20 Guidelines for Atypical Antipsychotics Atypical antipsychotics are restricted to the treatment of first episode psychosis or chronic psychosis in relapse. (national guidelines) First (and 2nd) line atypical antipsychotics: (alphabetical, no prescribed hierarchy) Aripiprazole Quetiapine Risperidone Ziprasidone 3rd line Olanzapine Clozapine (if poor response to AT LEAST 2 other atypical antipchotics) April 2007 VISN 20 P&T Committee VISN 20 Guidelines for Screening and Monitoring Patients Prescribed Atypical Antipsychotics Baseline Screening Guidelines Prior to initiating a new atypical antipsychotic, it is recommended that clinicians: 1. Obtain/review the patient's personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease. 2. Provide basic education about signs and symptoms of Hyperglycemia Diabetic ketoacidosis 3. Obtain or document in CPRS baseline measures for Fasting lipid panel and fasting blood sugar (or an HgA1C if it is difficult to get the patient's cooperation for a fasting blood sugar) Weight (entered into CPRS Cover Sheet)	FORMULARY

Height (entered into CPRS Cover Sheet)
Blood pressure (entered into CPRS Cover Sheet)

Subsequent Monitoring Guidelines

During the first 4 months of treatment, it is recommended that clinicians:

1. Obtain a fasting blood sugar and lipid panel at least once.
2. Record weight at each visit; note any increases.
3. Record blood pressure at least once.

At one year of treatment, it is recommended that clinicians:

1. Make sure that a recent weight and blood pressure are recorded in the chart.
2. Repeat fasting glucose.
3. Order a lipid panel if there are concerns about significant weight gain, personal or family risk factors for cardiovascular disease, or past abnormal laboratory results.

After one year, monitoring is at the clinician's discretion.

Considerations that would warrant further annual or more frequent screening include:

1. Significant amount of weight gain or pre-existing obesity
2. Family or personal history of other significant risk factors for cardiovascular disease or diabetes
3. Past abnormal laboratory screening results

Summary of VISN 20 Screening and Monitoring Recommendations

Measure	Baseline	First 4 Months	One Year
Personal/Family History	Yes		Review any changes
Patient/Family Education	Yes		

			Height Yes Weight (BMI) Yes Each visit Yes Fasting glucose/ Hgb A1c Yes At least once Yes Fasting lipid profile Yes At least once If clinically indicated Blood pressure Yes At least once Yes June 2005 VISN 20 P&T	
CN709	RISPERIDONE ORAL TABS	RISPERDAL	VISN 20 Guidelines for Atypical Antipsychotics Atypical antipsychotics are restricted to the treatment of first episode psychosis or chronic psychosis in relapse. (national guidelines) First (and 2nd) line atypical antipsychotics: (alphabetical, no prescribed hierarchy) Aripiprazole Quetiapine Risperidone Ziprasidone 3rd line Olanzapine Clozapine (if poor response to AT LEAST 2 other atypical antipchotics) April 2007 VISN 20 P&T Committee VISN 20 Guidelines for Screening and Monitoring Patients Prescribed Atypical Antipsychotics Baseline Screening Guidelines Prior to initiating a new atypical antipsychotic, it is recommended that clinicians: 1. Obtain/review the patient's personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease.	FORMULARY

			2. Provide basic education about signs and symptoms of Hyperglycemia Diabetic ketoacidosis 3. Obtain or document in CPRS baseline measures for Fasting lipid panel and fasting blood sugar (or an HgA1C if it is difficult to get the patient's cooperation for a fasting blood sugar) Weight (entered into CPRS Cover Sheet) Height (entered into CPRS Cover Sheet) Blood pressure (entered into CPRS Cover Sheet) Subsequent Monitoring Guidelines During the first 4 months of treatment, it is recommended that clinicians: 1. Obtain a fasting blood sugar and lipid panel at least once. 2. Record weight at each visit; note any increases. 3. Record blood pressure at least once. At one year of treatment, it is recommended that clinicians: 1. Make sure that a recent weight and blood pressure are recorded in the chart. 2. Repeat fasting glucose. 3. Order a lipid panel if there are concerns about significant weight gain, personal or family risk factors for cardiovascular disease, or past abnormal laboratory results. After one year, monitoring is at the clinician's discretion. Considerations that would warrant further annual or more frequent screening include: 1. Significant amount of weight gain or pre-existing obesity 2. Family or personal history of other significant risk factors for	

			cardiovascular disease or diabetes 3. Past abnormal laboratory screening results Summary of VISN 20 Screening and Monitoring Recommendations Measure Baseline First 4 Months One Year Personal/Family History Yes Review any changes Patient/Family Education Yes Height Yes Weight (BMI) Yes Each visit Yes Fasting glucose/ Hgb A1c Yes At least once Yes Fasting lipid profile Yes At least once If clinically indicated Blood pressure Yes At least once Yes June 2005 VISN 20 P&T	
AM800	RITONAVIR ORAL TABS	NORVIR	Restricted to ID Service or local equivalent	FORMULARY
AN900	RITUXIMAB INJ	RITUXAN	National PBM Drug Criteria for Non-Formulary Use RITUXIMAB (RITUXAN) Consider RITUXIMAB... ONLY as COMBINATION THERAPY with MTX if: - Documented suboptimal response to an adequate trial of MTX; AND - Documented contraindications, intolerance and/or suboptimal response to > 1 DMARDS at standard target dose (unless significant toxicity limited the dose tolerated), regardless of whether they were prescribed sequentially or in combination: oral/injectable gold, hydroxychloroquine, sulfasalazine, penicillamine, azathioprine, leflunomide; AND - Documented contraindications, intolerance and/or suboptimal response to > 1 BIOLOGIC DMARDS at standard target dose (unless significant toxicity limited the dose tolerated): etanercept, infliximab, adalimumab, anakinra CRITERIA FOR ELIGIBILITY*: * Each patient's risk versus benefit should be carefully considered before initiating therapy (or continuing therapy) in instances where safety and efficacy have not been established (See Table 4). Choice of therapy should be based on physician discretion and clinical judgment. 1. Diagnosis of RA as defined by the American College of Rheumatology (ACR); AND 2. Active RA despite full and adequate treatment with =/> 1 standard and biologic DMARDs at	FORMULARY

			standard or maximally tolerated dose; AND 3. Baseline monitoring parameters within normal limits (See Table 5). 4. In combination therapy with MTX only. CRITERIA FOR EXCLUSION: 1. MTX naive - If a patient has failed to demonstrate an adequate response to a single DMARD other than MTX, MTX should be initiated with doses up to 25mg/week (as tolerated) for at least 3 months, with or without other DMARDs; OR 2. If a patient has previously achieved remission on a given DMARD, he or she should be restarted on this previously effective DMARD prior to use of rituximab 3. Contraindications to rituximab (See Table 3). CRITERIA FOR CONTINUATION: After initiation of an agent, adequate response with decreased disease activity such as improvement in severity of affected joints or resolution of flares/decrease in flares within 2-24 weeks based on clinical judgment and quantitative measurements, including: 1. Improvement in validated quantitative measures of response such as the Health Assessment Questionnaire (HAQ), visual analog scales (VAS), Likert scales, joint tenderness and/or swelling, and laboratory data (ESR, CRP); AND 2. Improvement in the DAS score =/> 1.2; OR 3. Achievement of a DAS28 score of < 3.2; OR 4. > 20% improvement according to ACR 20% response criteria 5. Monitoring parameters at follow-up MUST be within normal limits (See Table 5). CRITERIA FOR WITHDRAWAL OF THERAPY: 1. Inefficacy - Inadequate response (despite confirmed compliance) within 4-8 weeks after starting treatment at the recommended dosing schedule (See Table 2); OR 2. Loss of efficacy/unacceptable disease activity after 3 consecutive months of maximum therapy despite confirmed compliance (i.e., Repetitive flares; progressive joint damage); OR 3. Development of drug-related toxicity or adverse events (See Tables 6 and 7). MAP/PBM August 2006; VISN 20 P&T Committee June 2007 Restricted to Rheumatology Services or local facility equivalent see: [paste entire URL into browser] http://vaww.pbm.va.gov/criteria/Criteria%20for%20Use%20for%20Leflunomide% 20and%20Biologic%20DMARDs.pdf	
MS300	ROCURONIUM INJ	ZEMURON	Restrictions per local facility	FORMULARY

CN500	ROPINIROLE ORAL TAB	REQUIP	Ropinirole is formulary, restricted to Neurology and Geriatrics Services or local facility equivalent for the treatment of Parkinson???s Disease, and restricted as a first-line agent for the treatment of RLS in patients on chronic dialysis and as a second-line agent for the treatment of Restless Leg Syndrome (RLS) in non-dialysis patients who have not responded or are intolerant to carbidopa/ levodopa. February 2008 VISN 20 P&T Committee	FORMULARY
CN204	ROPIVACAINE INJ	NAROPIN	Restricted to Anesthesiology Service or local facility equivalent	FORMULARY
OP900	ROSE BENGAL OPH STRIP (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE500	SALICYLIC ACID 2% SHAMPOO (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE752	SALICYLIC ACID 2% TOP CREAM (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE500	SALICYLIC ACID 2%/SULFUR 2% SHAMPOO (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE500	SALICYLIC ACID 2%/SULFUR 2% SOAP (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE500	SALICYLIC ACID 40% PLASTER	MEDIPLAST	Open Formulary - no restrictions	FORMULARY
MS101	SALSALATE 500MG, 750MG TAB	DISALCID	Open Formulary - no restrictions	FORMULARY
AM800	SAQUINAVIR ORAL	FORTOVASE	Restricted to ID Service or local equivalent	FORMULARY
BL400	SARGRAMOSTIM INJ	LEUKINE	NORTHWEST NETWORK (VISN 20) COLONY STIMULATING FACTOR (CSF) USAGE GUIDELINES: A. INDICATIONS [see below for Hep C criteria] 1. Patients with AIDS a. Absolute Neutrophil Count (ANC) less than 1,000 and with acute infection. b. ANC less than 500, and with history of a moderately severe bacterial or fungal infection. c. ANC less than 250. d. Any AIDS patient immediately following therapy for lymphoma. 2. Patients with severe constitutional neutropenia arising from bone marrow failure states other than acute myelogenous leukemia. Possible diagnoses include congenital neutropenia, cyclic neutropenia, hairy cell leukemia and aplastic anemia. 3. Patients with cancer: Patients should be treated with colony stimulating factor only when: a. There is an expectation for cure or prolonged disease-free survival as the result of a specific myelosuppressive therapy, and b. It is known that normal dose intensity is an important factor in a given case (from published literature or empirically), and c. One of the following: 1. There has been one prior episode of severe myelosuppression or the patient has AIDS or is over 65	FORMULARY

			years of age or there is an expected incidence of febrile neutropenia > 40%. 2. There has been a documented febrile neutropenia in a prior chemotherapy cycle. 3. In patients with newly diagnosed AML, GM-CSF (Sargramostim) may be used after completion of induction chemotherapy (particularly in patients > 55 years of age). 4. Patients with myelodysplastic syndromes who have severe anemia and/or are red blood cell transfusion dependent may benefit from a trial of G-CSF combined with recombinant human erythropoietin. B. AUTHORITY TO PRESCRIBE: Prescriptions for Colony Stimulating Factors require approval by a full-time physician from Hematology-Oncology or Infectious Disease Service within the Northwest Network. C. DOSING GUIDELINES: 1. Colony Stimulating Factors will not be administered 24 hours before or after a course of chemotherapy. 2. Therapy with G-CSF will be initiated with 5 mcg/kg subcutaneously daily for up to 2 weeks with routine motoring (twice weekly) of neutrophil counts, CBC and platelets. 3. CSFs may be given IV if subcutaneous dosing will result in undue bruising secondary to thrombocytopenia. 4. G-CSF will be administered to the day of recovery (ANC>500) of the first cycle or 2 days prior to that day and then stopped if the patient is afebrile (most treatment periods will be for 14-21 days). In general, those patients who fail to demonstrate a 2-3 fold increase in neutrophil count after 5 days of therapy can be increased immediately to 10 mcg/kg for 4 additional days. Those patients not responding after this dosage increase should be considered non-responders and therapy should be discontinued. The determination that a patient is a non-responder is at the judgment of the treating clinician and is not limited to a prescribed number of days or doses 5. GM-CSF for myelosuppressive chemotherapy-associated neutropenia (FDA approval pending) is initiated at a dose of 250 mcg/m2 subcutaneously each day following the guidelines listed for G-CSF listed. 6. Any increase in dosage with GM-CSF should be done cautiously because of reported dose-related toxicity with this agent. Caution should be used for doses that exceed 500 mcg/m2 daily. 7. Dosage adjustments should be made based on patient response to therapy. If the ANC>2000 (prior to the day of first course recovery) the dose should be decreased by 50% and maintained for 48 hours before further decreases or stoppage D. MARROW TRANSPLANT PROGRAM	

			USAGE: 1. CSF Usage Guidelines are developed in conjunction with Bone Marrow Transplant approved therapeutic protocols. 2. Clinical use of CSFs in autologous and allogeneic stem cell transplant is continuously under assessment, and use on the Marrow Transplant Unit (MTU) requires approval by the MTU attending physician. 3. Use of CSFs in MTU patients with poor engraftment may be approved by the MTU attending physician. ---------- Granulocyte Stimulating Colony Factor Criteria for Use for Hepatitis C Treatment-Related Neutropenia Patient Selection Before using a granulocyte colony stimulating factor: * Peginterferon dose has been reduced o Peginterferon alfa 2a reduction from 180mcg/week to 135mcg/week o Peginterferon alfa 2b reduction from 1.5mcg/kg/week to 1.0mcg/kg/week AND * Persistent severe neutropenia despite at least 2 weeks of reduced dose peginterferon along with: o ANC 500/mm3) * Maintain therapeutic dose of interferon-based preparation (generally, dose reductions of up to 40% do not appear to compromise SVR) * Reduced risk of infection and hospitalization Dosing and Monitoring (Refer to algorithm) * Filgrastim 300 mcg sq once or twice a week. * Titrate filgrastim dose to achieve ANC 500-1000/mm3. * Check nadir ANC just prior to the next dose to evaluate response every 1-2 weeks until stable * If ANC shows no increase or continues to decrease after at least 1 week of filgrastim, then further reduce or discontinue peginterferon and titrate filgrastim as above. o Investigate other potential cause for neutropenia (e.g., myelodysplasia) * If ANC >1000/mm3, stop filgrastim. for algorithm, please see: http://vaww.pbm.va.gov/criteria/GSCFCriteriaForUsefor HepatitisC.pdf National CFU - March 2006 VISN 20 P&T Committee April 21, 2006	
AU350	SCOPOLAMINE HBR INJ	HYOSCINE	Open Formulary - no restrictions	FORMULARY
OP600	SCOPOLAMINE HBR OPH SOLN	ISOPTO HYOSCINE	Open Formulary - no restrictions	FORMULARY
DX900	SECRETIN, HUMAN INJ, LYOPHILIZED	SECREFLO	Open Formulary - no restrictions	FORMULARY
CN602	SELEGELINE TRANSDERMAL PATCH	EMSAM	RESTRICTION(S) AND OTHER INFORMATION: VHA MAP/PBM-SHG Criteria-for-Use: Monoamine Oxidase Inhibitors (MAOI) for the Treatment of Major Depressive Disorder Oral and Transdermal Routes of Administration The criteria-for-use apply to all MAOIs prescribed for the treatment of major depressive disorder regardless of route of administration. Please	FORMULARY

			note at the time the criteria were developed no information was available on the efficacy or safety of transdermal selegiline for conditions other than major depressive disorder. The criteria do not apply to oral MAOIs being used to treat other conditions such as: Anxiety disorders; bipolar disorder; dysthymia; and Parkinson's disease (oral selegiline only). In order to receive an MAOI for the treatment of major depressive disorder, patients should meet the following: Have a diagnosis of major depressive disorder AND Have a prescription/order written by a psychiatrist or mental health provider AND Have failed to achieve remission (the absence of depressive symptoms or the presence of minimal depressive symptoms) after trials of two different antidepressants at therapeutic doses for at least 6 weeks OR Have demonstrated a therapeutic response to an MAOI in the past. PLUS ALL of the following must be met: The patient has no current contraindications to an MAOI (e.g., designated opiates, serotonin-active medications). See next page. The patient has not taken another antidepressant for a minimum of 2-5 weeks (see individual antidepressant labeling for specific washout period) prior to starting an MAOI. The patient demonstrates an understanding of and is willing to comply with the required dietary, herbal, and over-the-counter medications restrictions while taking an MAOI. The clinician-prescriber is willing or the facility has a system in place to answer the patient's questions about the medication 24 hours a day to avoid drug-drug and drug-food interactions. *The transdermal selegiline patch should not be cut. All MAOIs for depresssion (oral and patch) are restricted to psychiatry/mental health providers. Contraindications to MAOIs: Dietary sources rich in tyramine: Meat, Poultry and Fish o Air dried, aged, and fermented meats, sausages, salamis o Pickled herring o Spoiled or improperly stored meat, poultry or fish, including liver Vegetables o Broad bean pods, e.g., fava bean pods Dairy (milk products) o Aged cheeses, e.g., parmesan, cheddar Beverages o All tap beer, and other non-pasteurized beer Other o Concentrated yeast extract; Sauerkraut; Most soy products including soy sauce and tofu; and OTC supplements containing tyramine Medications which increase the risk of serotonin syndrome or hypertensive crisis Antidepressants o SSRIs - citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline o SNRIs - duloxetine, venlafaxine o Tricyclic, e.g., amitriptyline,	

			imipramine, desipramine, nortriptyline, clomipramine, doxepin o Mirtazapine o Bupropion o Other MAOIs (isocarboxazid, phenelzine, tranylcypromine, selegiline) o St. John's Wort Analgesics o Meperidine; tramadol; methadone; propoxyphene Anticonvulsants o Carbamazepin[Wed Nov 10 16:18:04 2010] dofile.pl: Wide character in print at c:\inetpub\wwwroot\reports \dofile.pl line 96. e; Oxcarbazepine Stimulants, including amphetamines Cough/Cold Products containing o Dextromethorphan o Decongestants, e.g., pseudoephedrine, phenylephrine Buspirone Cyclobenzaprine August 2007 VISN 20 P&T Committee	
CN500	SELEGILINE HCL ORAL	DEPRENYL	Restricted to Neurology Service or local equivalent	FORMULARY
TN499	SELENIUM INJ	N/A	Restrictions per local facility	FORMULARY
DE400	SELENIUM SULFIDE 2.5% LOTION/SHAMPOO	N/A	Open Formulary - no restrictions	FORMULARY
GA204	SENNA SYRUP (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
GA204	SENNOSIDES CONC TAB (OTC)	SENOKOT	Open Formulary - no restrictions	FORMULARY
CN609	SERTRALINE HCL 50MG, 100MG TAB	ZOLOFT	Sertraline, fluoxetine and citalopram are first line SSRIs. April 2007	FORMULARY
GU900	SEVELAMER CARBONATE	RENVELA	FORMULARY, CFU	FORMULARY
GU900	SEVELAMER CARBONATE ORAL	RENVELA	Criteria for Use Checklist Non-Calcium, Non-Aluminum Phosphate Binders (Lanthanum Carbonate, Sevelamer Carbonate, Sevelamer Hydrochloride) for the Management of Hyperphosphatemia in Chronic Kidney Disease VHA Pharmacy Benefits Management Services and Medical Advisory Panel INCLUSION CRITERIA FOR A NON-CALCIUM, NON-ALUMINUM PHOSHPHATE BINDER (must fulfill the following to be eligible) The non-calcium, non-aluminum phosphate binders (lanthanum carbonate, sevelamer carbonate, sevelamer hydrochloride) are restricted to Nephrology Service(a) and are to be used for the management of patients with chronic kidney disease (CKD) and hyperphosphatemia according to the criteria below: 0 Diagnosis of Stage 5 CKD (defined as kidney failure with GFR < 15 mL/min/1.73m2 or dialysis) and receiving kidney replacement therapy (i.e., hemodialysis or peritoneal dialysis) OR 0 Stage 3 to 5 CKD (refer to GFR range below) not receiving kidney replacement therapy Stage 3 CKD Stage 4 CKD Stage 5 CKD 30 to 59 mL/min/1.73m2 15 to 29 mL/min/1.73m2 < 15 mL/min/1.73m2 AND 0 Documented hyperphosphatemia AND one or more of	FORMULARY

			the following: 0 Serum phosphorus > 6.0 mg/dl (b) despite dietary restriction of phosphate to < 1gm/d AND adherence to maximally tolerated dose of calcium based phosphate binders (c) 0 Total serum calcium (corrected for serum albumin)(d) > 10.2 mg/dl (or maximum per lab/facility) on conventional treatment with calcium based phosphate binding therapy (c) and despite discontinuation of vitamin D preparations for at least 1 month 0 Intact plasma parathyroid hormone (PTH) level < 2 times the upper limit of normal (ULN) for PTH assay (K/DOQI Guideline recommendations < 150 pg/ml based on assay with ULN 75 pg/ml) with normal or elevated serum calcium (corrected for serum albumin;(d) elevated > 10.2 mg/dl or maximum per lab/facility) associated with adynamic bone disease 0 Calcium x phosphorus product > 55 mg2/dl2 despite dietary restriction of phosphate to < 1 gm/d AND calcium based phosphate binders (c) notes - a) Restricted to Nephrology for the initial prescription; if deemed appropriate, local P&T Committees may approve selected providers to renew prescriptions b) Kalantar-Zadeh K, et al. Survival predictability of time-varying indicators of bone disease in maintenance hemodialysis patients. Kidney Int 2006;70:771-80. Block GA, et al. Mineral metabolism, mortality, and morbidity in maintenance hemodialysis. J Am Soc Nephrol 2004;15:2208-18. Ganesh SK, et al. Association of elevated serum PO4, Ca, Ca X PO4 product, and parathyroid hormone with cardiac mortality risk in chronic hemodialysis patients. J Am Soc Nephrol 2001;12:2131-8. Block GA, et al. Association of serum phosphorus and calcium x phosphorus product with mortality risk in chronic hemodialysis patients: a national study. Am J Kidney Dis 1998;31:607-17. c) An aluminum containing phosphate binder should NOT be used for long-term management of hyperphosphatemia due to potential toxicity. K/DOQI Guideline recommendations are to limit elemental calcium intake from phosphate binders to < 1500 mg/d, with the total daily intake (including dietary calcium) of elemental calcium not to exceed 2,000 mg. In addition, use of 2.5mEq/L calcium dialysate or lower, if indicated should be part of therapy to reduce hypercalcemia. d) Calculation for corrected total serum calcium=total calcium + 0.8 (4 - serum albumin) [4 gm/dl (normal serum albumin) - most recent serum albumin] Ex. Calcium 9.9 mg/dl; albumin 3.2 gm/dl [4 - 3.2] = 0.8; 0.8 X 0.8 = 0.64 9.9 + 0.64 = 10.54 (10.5 mg/dl is the	

			corrected serum calcium) EXCLUSION CRITERIA (if ONE is checked, patient is not eligible) Lanthanum carbonate 0 Hypophosphatemia Sevelamer carbonate or sevelamer hydrochloride 0 Hypophosphatemia 0 Bowel obstruction DOSING RECOMMENDATIONS 0 Lanthanum carbonate: initial recommended dose is 250 mg to 500 mg three times daily; doses may be increased by 750 mg every 2 to 3 weeks until serum phosphorus goal is achieved. Usual maintenance dose (to achieve phosphorus < 6.0 mg/dl in clinical trials) is 500 mg to 1000 mg three times daily (maximum dose studied 3750 mg daily in divided doses); doses should be administered with meals. The manufacturer recommends that medications that interact with antacids should not be administered within 2 hours of lanthanum carbonate. 0 Sevelamer carbonate or sevelamer hydrochloride: initial recommended dose is 800 mg to 1600 mg three times daily; doses may be increased by 800 mg three times daily every 2 weeks, based on response. Usual maintenance dose (to achieve phosphorus < 5.0 mg/dl in clinical trials) is 2400 mg three times daily (maximum dose studied are 14 gm daily for sevelamer carbonate and 13 gm daily for sevelamer hydrochloride in divided doses); doses should be administered with meals. Patients receiving medications where a reduction in bioavailability may result in a significant clinical impact on the safety or efficacy of the medication should be instructed to take the medication at least 1 hour before or 3 hours after sevelamer carbonate or sevelamer hydrochloride, or the provider should consider monitoring blood levels of the medication. MONITORING 0 Lanthanum carbonate: serum phosphorus levels should be monitored as needed during titration and regularly once on maintenance dose 0 Sevelamer carbonate and sevelamer hydrochloride: phosphorus, bicarbonate, chloride levels should be monitored. Rare cases of increased TSH reported with concomitant levothyroxine; monitor TSH in patients taking sevelamer carbonate or sevelamer hydrochloride and levothyroxine 0 If the patient does not respond adequately despite prescribing the maximum studied doses, reevaluate adherence to the medication regimen and to dietary restrictions. Consider referral to dietitian and reinforce importance of medication adherence RECOMMENDATIONS FOR DISCONTINUATION OR DECREASE IN DOSE 0 Patient does not experience an improvement in serum	

			phosphorus 0 Patient experiences a significant drug related adverse event VISN 20 P&T Committee January 2009, June 2010	
CN203	SEVOFLURANE INHALATION	ULTANE	Restrictions per local facility	FORMULARY
XA900	SHARPS DISPOSABLE CONTAINER	N/A	Open Formulary - no restrictions	FORMULARY
XA900	SHEATH HOLDER WITH VELCRO/FOAM	N/A	Open Formulary - no restrictions	FORMULARY
DE500	SILVER NITRATE APPLICATORS	N/A	Open Formulary - no restrictions	FORMULARY
DE101	SILVER SULFADIAZINE 1% CREAM	SILVADENE	Open Formulary - no restrictions	FORMULARY
GA900	SIMETHICONE 80MG CHEW TAB	MYLICON	Open Formulary - no restrictions	FORMULARY
CV350	SIMVASTATIN ORAL TAB	ZOCOR	FIRST LINE drug	FORMULARY
IM600	SIROLIMUS ORAL SOLUTION	RAPAMUNE	Restricted to patients unable to take oral tablets.	FORMULARY
IM600	SIROLIMUS TAB, ORAL	RAPAMUNE	Restricted to transplant services or local equivalent.	FORMULARY
XA604	SKIN BARRIER	N/A	Open Formulary - no restrictions	FORMULARY
XA900	SKIN CLEANSER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	SKIN CLEANSER, INTACT	N/A	Open Formulary - no restrictions	FORMULARY
XA199	SOCK, STUMP	N/A	Open Formulary - no restrictions	FORMULARY
TN404	SODIUM ACETATE 2MEQ/ML INJ 20M	N/A	Open Formulary - no restrictions	FORMULARY
GA110	SODIUM BICARBONATE 325MG TAB	N/A	Open Formulary - no restrictions	FORMULARY
TN409	SODIUM BICARBONATE INJ 50MEQ/5	N/A	Open Formulary - no restrictions	FORMULARY
NT900	SODIUM CHLORIDE 0.65% NASAL SOLN	N/A	Open Formulary - no restrictions	FORMULARY
IR100	SODIUM CHLORIDE 0.9% IRRG SOLN	N/A	Open Formulary - no restrictions	FORMULARY
TN102	SODIUM CHLORIDE 3% INJ 1000ML	N/A	Open Formulary - no restrictions	FORMULARY
OP900	SODIUM CHLORIDE 5% OPH OINT	N/A	Open Formulary - no restrictions	FORMULARY
OP900	SODIUM CHLORIDE 5% OPH SOLN	N/A	Open Formulary - no restrictions	FORMULARY
RE900	SODIUM CHLORIDE INHL (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
TN102	SODIUM CHLORIDE INJ 0.45% 1000	N/A	Open Formulary - no restrictions	FORMULARY
PH000	SODIUM CHLORIDE INJ 0.9% 10ML, 20ML, 100ML	N/A	Open Formulary - no restrictions	FORMULARY
TN102	SODIUM CHLORIDE INJ 0.9% 250ML, 500ML	N/A	Open Formulary - no restrictions	FORMULARY
TN102	SODIUM CHLORIDE INJ 0.9% 1000M	N/A	Open Formulary - no restrictions	FORMULARY

OP900	SODIUM CHONDROITIN/HYALURONATE OPHTH INJ	VISCOAT	Open Formulary - no restrictions	FORMULARY
TN404	SODIUM CITRATE INJ	N/A	Open Formulary - no restrictions	FORMULARY
TN102	SODIUM CITRATE ORAL SOLN	N/A	Open Formulary - no restrictions	FORMULARY
TN102	SODIUM CITRATE POWDER	N/A	Open Formulary - no restrictions	FORMULARY

OR100	SODIUM FLUORIDE 1.1% DENTAL GEL,ORAL CREAM, 5% DENTAL VARNISH	N/A	Restricted to Dental Service according to risk category table: Recommendations for the use of Sodium Fluorides Indicators and Risk Factors by Caries Risk Category Risk Category Indicators and Risk Factors Low No carious lesions within the last 3 years Good salivary flow Evidence of good daily oral care (DRM Plaque index score of 0-1) Regular dental visits (at least 1x/year) Moderate 1-2 new carious lesions within the last 3 years Evidence of moderate daily oral care (DRM Plaque score of 1-2) Frequent carbohydrate or sugar intake Inadequate fluoride exposure (brushing less than 2x/day and no other fluoride source) Use of medications that could cause reduced salivary flow, but no clinical signs History of sporadic or no dental care Use of a removable partial denture High 3 or more new carious lesions within the last 3 years Reduced salivary flow Evidence of poor daily oral care (DRM Plaque score of 2-3) Medical conditions that contribute to caries susceptibility (ex: head and neck radiation therapy, psychiatric conditions, drug abuse and others) Exposed root surfaces Frequent carbohydrate or sugar intake along with low daily fluoride exposure Inadequate fluoride exposure (brushing less than 2x/day and no other fluoride source) History of sporadic or no dental care Recommendations for the VA Dental Population (Fluoride Use Strategies Based on Risk Category) RISK CATEGORY Professional Use Recommendations Supplemental Fluoride Recommendations Low Community water fluoridation * Fluoride dentifrice (~1100ppm) * Moderate 5% Na Fluoride varnish q 3-6 months 0.05%Na Fluoride rinse 1-2 x/day OR 2% neutral Na Fluoride gel applied q 3-6 months 1.1% Na Fluoride paste used 1-2x daily OR 1.23% APF fluoride gel q 3-6 months (no porcelain or composites) 1.1% Na Fluoride paste used 1-2x daily High 5% Na fluoride varnish q 3-4 months 1.1% Na Fluoride gel *5 minutes in custom trays daily OR 2% neutral Na Fluoride gel applied q3-4 months 1.1% Na Fluoride paste used 1-2 x daily OR 1.23% APF fluoride gel q 3-4 months (no porcelain or composites) 1.1% Na Fluoride gel brushed on at bedtime after brushing with a OTC toothpaste October 2008 VISN 20 P&T Committee	FORMULARY
DE109	SODIUM HYPOCHLORITE 0.0125% TOP SOLN (OTC)	DAKIN'S SOLN, MODIFIED, 1/40TH STRENGTH	Open Formulary - no restrictions	FORMULARY

DE109	SODIUM HYPOCHLORITE 0.125% TOP SOLN (OTC)	DAKIN'S SOLN, MODIFIED 1/4TH STRENGTH	Open Formulary - no restrictions	FORMULARY
DE109	SODIUM HYPOCHLORITE 0.25% TOP SOLN (OTC)	DAKIN'S SOLN, MODIFIED, 1/2 STRENGTH	Open Formulary - no restrictions	FORMULARY
DE109	SODIUM HYPOCHLORITE 0.5% TOP SOLN (OTC)	DAKIN'S SOLN, MODIFIED, FULL STRENGTH	Open Formulary - no restrictions	FORMULARY
TN102	SODIUM LACTATE INJ	N/A	Open Formulary - no restrictions	FORMULARY
GA202	SODIUM PHOSPHATE 1.5GM TAB	OSMOPREP	Restricted to GI Service or local facility equivalent.	FORMULARY
TN408	SODIUM PHOSPHATE INJ 3MM/ML	N/A	Open Formulary - no restrictions	FORMULARY
AD400	SODIUM POLYSTYRENE SULFONATE RTL SUSP	KAYEXALATE	Open Formulary - no restrictions	FORMULARY
AD400	SODIUM POLYSTYRENE SUSP 15GM/60ML	KAYEXALATE	Open Formulary - no restrictions	FORMULARY
PH000	SORBITOL 70% SOLN	N/A	Open Formulary - no restrictions	FORMULARY
CV100	SOTALOL HCL ORAL	BETAPACE	Open Formulary - no restrictions	FORMULARY
XA900	SPACER-INHALER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	SPIKE,ASPIRATING,STERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CV704	SPIRONOLACTONE 25MG TAB	ALDACTONE	Open Formulary - no restrictions	FORMULARY
CV704	SPIRONOLACTONE 50MG TAB	ALDACTONE	Open Formulary - no restrictions	FORMULARY
CV704	SPIRONOLACTONE 100MG TAB	ALDACTONE	Open Formulary - no restrictions	FORMULARY
AM800	STAVUDINE (d4T) ORAL	ZERIT	Restricted to ID Service or local equivalent	FORMULARY
XA199	STERI-STRIPS	N/A	Open Formulary - no restrictions	FORMULARY
XA608	STOMA CAP (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
BL600	STREPTOKINASE INJ 750,000 UNIT	KABIKINASE	Restrictions per local facility	FORMULARY
AM300	STREPTOMYCIN SULFATE INJ	N/A	Open Formulary - no restrictions	FORMULARY
AN200	STREPTOZOCIN INJ	ZANOSAR	Restrictions per local facility	FORMULARY
MS300	SUCCINYLCHOLINE INJ	ANECTINE	Restrictions per local facility	FORMULARY
GA302	SUCRALFATE 1GM TAB	CARAFATE	Open Formulary - no restrictions	FORMULARY
GA302	SUCRALFATE ORAL SUSPENSION	CARAFATE	Open Formulary - no restrictions	FORMULARY
XA900	SUCTION TIPS, YANKAUR	N/A	Open Formulary - no restrictions	FORMULARY
CN101	SUFENTANIL CITRATE INJ	SUFENTA	Restrictions per local facility	FORMULARY
OP201	SULFACETAMIDE NA 10% OPH OINT	BLEPH-10 S.O.P.	Open Formulary - no restrictions	FORMULARY
DE500	SULFACETAMIDE NA 10%/SULFUR 5% LOTION	SULFACET-R	Open Formulary - no restrictions	FORMULARY

OP201	SULFACETAMIDE OPHTH SOLN 10%	SULAMYD	Open Formulary - no restrictions	FORMULARY
AM650	SULFADIAZINE ORAL	N/A	Restricted to ID Service or local equivalent	FORMULARY
AM650	SULFAMETHOX 200MG/TRIMETHOPRIM 40MG SUSP	BACTRIM	Open Formulary - no restrictions	FORMULARY
AM650	SULFAMETHOX 80MG/TRIMETHOPRIM 16MG INJ	BACTRIM	Open Formulary - no restrictions	FORMULARY
AM650	SULFAMETHOXAZOLE/TRIMETHOPRIM TAB	BACTRIM	Open Formulary - no restrictions	FORMULARY
GA900	SULFASALAZINE 500MG EC TAB	AZULFIDINE	Open Formulary - no restrictions	FORMULARY
GA900	SULFASALAZINE 500MG TAB	AZULFIDINE	Open Formulary - no restrictions	FORMULARY
MS102	SULINDAC 150MG, 200MG TAB	CLINORIL	Open Formulary - no restrictions	FORMULARY
CN105	SUMATRIPTAN SUCCINATE INJ	IMITREX	VISN 20 5HT-1D (serotonin) receptor agonist ("triptan") Criteria: SUMATRIPTAN oral tabelts are open formulary, first line Zolmatriptan is formulary, second line, reserved for patients intolerant to sumatriptan oral tablets Naratriptan is non-formulary, second line, reserved for patients who cannot be successfully treated with sumatriptan or zolmitriptan. January 2010 VISN 20 P&T The following has useful information, but no represent longer current restrictions. PREVIOUS VISN SUMATRIPTAN CRITERIA FOR USE 1) Sumatriptan, a 5HT-1D (serotonin) receptor agonist, is approved only for treatment of classic and common migraine. It is not used for basilar or hemiplegic migraine headaches. 2) Generally, the first dose should be given under medical supervision. If the first dose is given outside the VA, there should be some notification and documentation of the effectiveness of sumatriptan. 3) Patients can receive sumatriptan from a provider if	FORMULARY

NSAIDS, ergotamine, or dihydroergotamine (DHE) therapy have been shown to be ineffective or not tolerated.

4) Patients should not get sumatriptan if there is a contraindication such as ischemic heart disease (angina, history of MI, documented silent ischemia), Prinzmetal's angina, uncontrolled hypertension, pregnancy or women trying to get pregnant, or hypersensitivity. In addition, sumatriptan should not be used concomitantly with ergot-containing preparations.

5) Sumatriptan has many potential adverse effects including: dizziness; flushing; nasal discomfort; pressure sensations throughout the body; taste disturbances; nausea; myocardial infarction; arrhythmias; renal failure; CVA; and angina.

6) Administration, dosing, and cost of individual dosage forms:

A. Sumatriptan Injectable (6mg injection - $24.81 each)

1. Suggested dosage: One 6mg injection SC at start of headache may repeat in 1 hour if needed. Manufacturer states that if the first injection provides NO relief, then a second injection is unlikely to be of benefit.
2. No more than 12mg (2 injections) per headache.
3. Sumatriptan injectable will be limited to the treatment of 4 headaches per month (8 syringes per month). Monthly cost is $198.

B. Sumatriptan Oral (25mg tablet - $6.62 each) (50mg tablet - $7.56 each)

1. The recommended dosage is 25-50mg at the start of migraine. Subsequent 25-50mg doses may be taken at least 2 to 4 hours after each previous dose, if needed.
2. No more than 200mg in a 24 hour period per headache.
3. Sumatriptan oral will be limited to the treatment of 4 headaches per month (16 doses per month). Monthly cost is $106 (25mg tablet) or $121 (50mg tablet).

C. Sumatriptan Nasal Spray (20mg dose - $10.36 each)

1. Improved efficacy over oral formulation.

			2. Recommended dosage is one 20mg spray in one nostril, may repeat in 2 hours. 3. No more than 40mg (2 doses) in a 24-hour period. 4. There is evidence that taking doses larger than 20mg does not increase efficacy. 5. Sumatriptan nasal spray will be limited to 4 migraines per month (8 doses per month). Monthly cost is $83. D. Efficacy Rates Drug Efficacy Rate Sumatriptan injectable 70% Sumatriptan nasal spray 64% Sumatriptan oral (all doses) 54% 7) Sumatriptan is contraindicated in patients with hepatic insufficiency and renal failure. 8) In patients exhibiting one or more of the following risk factors, sumatriptan dosage will not be increased: hypertension; strong family history of CAD; hypercholesterolemia; obesity; post-menopausal women; diabetes; smoker; males > 40 years; and any other causes of headache. 9) In patients where more than 8 doses for injectable or nasal spray or 16 doses for oral per month are desired, another route of administration of sumatriptan should be tried. If all forms of therapy have been tried, a non-formulary drug request must be submitted and approved by Neurology Service or local medical center equivalent specialist prior to dispensing. 10) All patients requiring more than 8 doses for injectable or nasal spray or 16 doses for oral per month should be reviewed for use of migraine prophylactic medications to include one or more of the following: divalproex (Depakote); propranolol (Inderal); amitriptyline (Elavil); or verapamil (Calan). Date Added: Date(s) Discussed: August 21, 1998	
CN105	SUMATRIPTAN SUCCINATE ORAL TAB	IMITREX	Open Formulary - no restrictions	FORMULARY

DE300	SUNSCREEN-30 PABA-FREE COMBINATION LOTION (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	SUSPENSORY SUPPORTER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	SUTURE REMOVAL KIT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA859	SYRINGE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	SYRINGE MAGNIFIER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA856	SYRINGE NEEDLES (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA852	SYRINGE, LUER LOCK	N/A	Open Formulary - no restrictions	FORMULARY
PH000	TABLET CUTTER	N/A	Open Formulary - no restrictions	FORMULARY
IM600	TACROLIMUS INJ	PROGRAF	Restrictions per local facility	FORMULARY
IM600	TACROLIMUS ORAL	PROGRAF	Restricted to transplant services or local equivalent.	FORMULARY
DE900	TALC TOP PWD (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
AN500	TAMOXIFEN CITRATE ORAL	NOLVADEX	Restricted to Oncology Service or local equivalent	FORMULARY
CV150	TAMSULOSIN CAPSULE		FORMULARY, CFU	FORMULARY
XA299	TAPE RETENTION SHEET	N/A	Open Formulary - no restrictions	FORMULARY
XA202	TAPE, CLOTH	N/A	Open Formulary - no restrictions	FORMULARY
XA204	TAPE, FOAM (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA202	TAPE, MICROPORE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA201	TAPE, PAPER	N/A	Open Formulary - no restrictions	FORMULARY
XA202	TAPE, PAPER 1IN F#338-5405	N/A	Open Formulary - no restrictions	FORMULARY
XA299	TAPE, PINK	N/A	Open Formulary - no restrictions	FORMULARY
XA203	TAPE, PLASTIC (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA203	TAPE, PLASTIC TRANSPORE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA203	TAPE, SURGICAL PLASTIC STRETCH (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA206	TAPE, TRACH	N/A	Open Formulary - no restrictions	FORMULARY
XA202	TAPE, WATER REPELLENT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA104	TELFA ADHESIVE PAD (OTC)	TELFA	Open Formulary - no restrictions	FORMULARY
XA103	TELFA PAD NON-ADHESIVE 3IN X 4IN (OTC)	TELFA	Open Formulary - no restrictions	FORMULARY
CN302	TEMAZEPAM ORAL	RESTORIL	Open Formulary - no restrictions	FORMULARY
BL600	TENECTEPLASE,RECOMBINANT INJ	TNKASE	Restricted to the treatment of acute MI.	FORMULARY

AN900	TENIPOSIDE INJ	VUMON	Restrictions per local facility	FORMULARY
AM800	TENOFOVIR ORAL TAB	VIREAD	Tenofovir is formulary, restricted to HIV providers or local facility equivalent for the treatment of HIV and to ID and GI providers or local facility equivalents for treatment of Hepatitis B. VISN 20 P&T Committee November 2008	FORMULARY
CV150	TERAZOSIN HCL 1MG, 2MG, 5MG CAPSULE	HYTRIN	Open Formulary - no restrictions	FORMULARY
DE102	TERBINAFINE HCL 1% TOP CREAM	LAMISIL	Restricted to Dermatology Service or local facility equivalent.	FORMULARY
AM700	TERBINAFINE HCL ORAL	LAMISIL	Restricted to the treatment of non-cosmetic onychomycosis	FORMULARY
AU100	TERBUTALINE INJ 1MG/ML	BRETHINE	Restrictions per local facility	FORMULARY
RE103	TERBUTALINE SULFATE 2.5MG, 5MG TAB	BRETHINE	Open Formulary - no restrictions	FORMULARY
HS100	TESTOSTERONE INJ IN OIL 200MG/ML	N/A	Restrictions per local facility	FORMULARY
HS100	TESTOSTERONE PATCH	TESTODERM	Restricted to pts unable to use injectable form	FORMULARY
IM300	TETANUS ANTITOXIN INJ	N/A	Open Formulary - no restrictions	FORMULARY
IM500	TETANUS IMMUNE GLOBULIN 250 UN	N/A	Open Formulary - no restrictions	FORMULARY
CN204	TETRACAINE HCL INJ	PONTOCAINE	Open Formulary - no restrictions	FORMULARY
OP700	TETRACAINE HCL OPH SOLN	PONTOCAINE	Open Formulary - no restrictions	FORMULARY
AM250	TETRACYCLINE HCL 250MG CAP	N/A	Open Formulary - no restrictions	FORMULARY
XA513	TEXAS CATHETER	N/A	Open Formulary - no restrictions	FORMULARY
IM900	THALIDOMIDE ORAL	THALOMID	Thalidomide (Thalomid®) is formulary, restricted to VA Hematologist and Oncologists May 2007, May 2010 The VHA Clinical Guidance for the Initial management of Adults with Multiple Myeloma was completed in August 2009 by the PBM, MAP, and VACO Oncology Service Consultants. It provides a treatment algorithm for patients with symptomatic Multiple Myeloma (MM). Multiple myeloma is part of a spectrum of diseases that involves the neoplastic proliferation of a monoclonal plasma cell clone that produces immunoglobulins. Clinical manifestations, including anemia, bone pain, pathologic fractures, infections, hypercalcemia, renal failure, and coagulopathy are the result of tumor	FORMULARY

			involvement in the bone marrow, the effect of myeloma protein on various end organs, cytokine production by tumor cells or by the bone marrow microenvironment, and deficiencies in humoral and cellular immunity. Patients with smoldering (asymptomatic) myeloma do not require immediate therapy, as therapy provides no clear benefit in this population. There is no standard initial therapy for patients who are not transplant candidates. The regimens with the highest level of evidence to date are the triplet regimens of melphalan plus prednisone and either thalidomide or bortezomib. The addition of thalidomide or bortezomib to melphalan plus prednisone is associated with additional toxicity. Preliminary reports of two and three year survival data with lenalidomide plus dexamethasone have consistently shown good results; while the data are encouraging, there is a need for further follow-up published in peer-reviewed journals. Melphalan and prednisone alone may be used in patients who do not tolerate the novel agents, but response rates to these are lower than with triplet therapies or lenalidomide plus dexamethasone. Upon disease progression, patients should be offered one of the three newer agents which have been shown to benefit overall survival. Initial treatment is based on patients??? candidacy for transplant and other pre-existing conditions. Date Added: October 16, 2009 Date(s) Discussed: May 18, 2007	
RE104	THEOPHYLLINE INJ	N/A	Restrictions per local facility	FORMULARY
RE104	THEOPHYLLINE ORAL	N/A	Open Formulary - no restrictions	FORMULARY
AP200	THIABENDAZOLE ORAL	MINTEZOL	Open Formulary - no restrictions	FORMULARY
VT105	THIAMINE HCL 100MG TAB	VITAMIN B-1	Open Formulary - no restrictions	FORMULARY
VT105	THIAMINE INJ 100MG/ML	VITAMIN B-1	Open Formulary - no restrictions	FORMULARY
TN200	THICKENING ORAL POWDER	THICKENUP	Open Formulary - no restrictions	FORMULARY
AN300	THIOGUANINE ORAL	N/A	Restricted to Oncology Service or local equivalent	FORMULARY
CN202	THIOPENTAL INJ	N/A	Open Formulary - no restrictions	FORMULARY

CN701	THIORIDAZINE HCL 10, 15, 25, 50, 100, 200MG TAB	MELLARIL	Open Formulary - no restrictions	FORMULARY
CN701	THIORIDAZINE ORAL CONC 30MG/ML	MELLARIL	Open Formulary - no restrictions	FORMULARY
AN100	THIOTEPA INJ	THIOPLEX	Restrictions per local facility	FORMULARY
CN701	THIOTHIXENE HCL 1, 2, 5, 10, 20MG CAP	NAVANE	Open Formulary - no restrictions	FORMULARY
CN701	THIOTHIXENE ORAL SOLN 5MG/ML	NAVANE	Open Formulary - no restrictions	FORMULARY
NT300	THROAT LOZENGE (OTC)	CEPACOL	Open Formulary - no restrictions	FORMULARY
BL300	THROMBIN 5000 UNITS TOPICAL POWDER	N/A	Open Formulary - no restrictions	FORMULARY
AM054	TICARCILLIN/CLAVULANATE K INJ	TIMENTIN	Restrictions per local facility	FORMULARY
AM250	TIGECYCLINE INJ	TYGACIL	Recommendation of Use for Tigecycline (Tygacil) JUNE 2009 Pharmacy Benefits Management Services and the Medical Advisory Panel FDA APPROVED INDICATION(S) FOR USE - Complicated intra-abdominal infections - Complicated skin and skin structure infections - Community- acquired bacterial pneumonia EXCLUSION CRITERIA (If one is selected, patient is NOT eligible) 0 Clinical evaluation of patient with positive microbiology culture(s) is consistent with colonization (not active infection). 0 Known resistance to tigecycline 0 Treatment of urinary tract infection. 0 Monotherapy for complicated intra-abdominal infection caused by bowel perforation. Contraindications: 0 Known hypersensitivity to tigecycline or tetracycline class antibiotics. 0 Pregnancy (Classified as Pregnancy Category D). 0 Children = 8 years. CAUTION Tigecycline should not be used in the treatment of ventilator-associated pneumonia if there are other viable antimicrobial	FORMULARY

			choices. INCLUSION CRITERIA MRSA Infection (Select one indication and clinical scenario) 0 Documented MRSA intra-abdominal. 0 Documented complicated skin and skin structure infection caused by MRSA. 0 Other documented, serious MRSA infections (except pneumonia) AND, one of the following clinical scenarios: 0 Infection is unresponsive to vancomycin despite therapeutic vancomycin concentrations. 0 In vitro non-susceptibility to vancomycin (including heteroresistant VISA strains). 0 Patient does not tolerate vancomycin (i.e., allergy or serious adverse drug reaction) and treatment with an oral agent (e.g., TMP/SMX, minocycline, doxycycline or clindamycin) is not appropriate. Gram-Negative Infection (Select one indication and clinical scenario) 0 Systemic infection due to multi-drug resistant Acinetobacter spp. or extended-spectrum beta-lactamase-producing organisms (e.g., Klebsiella or E. coli). AND one of the following clinical scenarios: 0 Resistance to carbapenems and fluoroquinolones. 0 Intolerance to carbapenems, beta-lactams, and fluoroquinolones (i.e., allergy or serious adverse drug reaction). Other Infections (Select one to be eligible) 0 Documented VRE intra-abdominal infection. 0 Consolidation therapy with tigecycline (e.g., replacement of therapy with vancomycin plus broad-spectrum beta-lactam antibiotics or carbapenems with tigecycline monotherapy): This should be	

			avoided in hospital-acquired pneumonia and limited to circumstances where the pathogens are documented to be susceptible to tigecycline. July 2009 VISN 20 P&T Committee . Date Added: Date(s) Discussed: July 17, 2009	
OP101	TIMOLOL OPHTH GEL	TIMOPTIC XE	Open Formulary - no restrictions	FORMULARY
OP101	TIMOLOL OPHTH SOLN	TIMOPTIC	Open Formulary - no restrictions	FORMULARY
RE105	TIOTROPIUM INHALATION CAPSULE	SPIRIVA	Criteria for Use for Tiotropium (Spiriva) VHA Pharmacy Benefits Management Service and Medical Advisory Panel Exclusions for maintenance therapy (if ONE is checked, patient is not eligible) () Asthma without COPD () Hypersensitivity to ipratropium or tiotropium () Patient with mild COPD or those with few or intermittent symptoms who do not require chronic daily maintenance therapy Inclusions for maintenance therapy (all 3 criteria must be met) Inclusions for maintenance therapy (all 3 criteria must be met) () COPD of moderate or worse severity (i.e. FEV1/FVC < 70 and FEV1 < 80% of predicted value) () Symptom control requires chronic daily treatment with an anticholinergic inhaler+ () No concurrent use of ipratropium or	FORMULARY

			ipratropium/albuterol with tiotropium (d/c ipratropium or ipratropium/albuterol if tiotropium started or vice versa) + In lieu of tiotropium, ipratropium or ipratropium/albuterol administered on a scheduled basis remain as treatment options. Special Considerations Patient should be receiving a short-acting beta-agonist for "as needed" use. Patients who are stable and well-controlled on current doses of ipratropium or ipratropium/albuterol may continue using the agent rather than being automatically switched to tiotropium, unless other clinical reasons exists (e.g., adherence, ease of use) Since formoterol is also a dry powder capsule, patients also using formoterol must be instructed to use the correct delivery device for the correct drug (tiotropium with Handihaler and formoterol with Aerolizer) Discontinue tiotropium at once and consider alternatives if immediate hypersensitivity reactions, including angioedema, occur. Given the similar structural formula of atropine to tiotropium, patients with a history of hypersensitivity reactions to atropine should be closely monitored for similar hypersensitivity reactions to tiotropium. Use with caution in patients with severe hypersensitivity to milk proteins (not lactose intolerance).	

			Dose Two inhalations of the powder contents of a single tiotropium capsule (18 mcg) once daily Presently, there is NO EVIDENCE that an increased dose over the initial recommend daily dose of 18mcg once daily is of benefit. Renewal In (re)evaluating the therapeutic impact of tiotropium, consider if the patient has had improvement in symptoms or reduction in COPD exacerbations. May 2010 VISN20 P&T Committee Date Added: January 19, 2007 Date(s) Discussed: March 18, 2005	
AM800	TIPRANAVIR ORAL	APTIVUS	Tipranavir (Aptivus) Criteria for Use Patient Selection for Treatment: Needs to meet all of the criteria O Patients should be highly treatment-experienced including at least 2 prior failed PI regimens. AND O Have evidence of virologic failure (documented by a viral load > 1,000 copies/ml) and evidence of genotypic or phenotypic resistance on their current PI regimen. AND	FORMULARY

			O Not have more than two mutations at codons L33V/I/F, V82T, I84V or L90M or a phenotypic cutoff greater that 4 (using the PhenoSense assay) before initiating TPV/r as the presence of theses mutations and this cutoff is associated with decreased efficacy and makes it highly unlikely that TPV will have any activity. Genotypic or phenotypic testing and/or treatment history should guide the use of TPV/r. AND O Have the ability to construct a multi-drug regimen that includes preferably two other active anti-retroviral drugs in addition to TPV/r. Resistance testing is to be used in determining a reasonable ARV backbone regimen to be combined with TPV/r and should be assessed prior to initiating treatment with TPV/r. Consideration should be given to using enfuvirtide as part of an active antiretroviral regimen when initiating TPV/r treatment, as there was a higher treatment response for those who also used enfuvirtide than for those who did not use it. TPV/r should be added to an existing, failing regimen only if there is evidence that one or more drugs in that regimen may retain activity, and no other active drugs are available. AND O Patient must be able to tolerate low dose ritonavir (200mg) twice a day. Tipranavir MUST be administered with low dose ritonavir to achieve its desired efficacy. ----------	

			Contraindications of Therapy: O Patients with moderate and severe (Child-Pugh Class B and C, respectively) hepatic insufficiency. The tipranavir label includes a Black Box warning regarding hepatoxicity. Co-administration of TPV with low dose ritonavir has been associated with reports of clinical hepatitis and hepatic decompensation, including some fatalities. The warning states that extra vigilance is warranted in patients with chronic hepatitis B or hepatitis C co-infection, as these patients have an increased risk of hepatotoxicity. O Tipranavir undergoes cytochrome p450 metabolism and is known to inhibit isoenzymes 3A4, and 2D6. The following medications are contraindicated with TPV and ritonavir co-administration: antiarrhythmics (amiodarone, bepredil, flecanide, propafenone, quinidine); cisapride; astemizole, terfenadine; ergot derivatives; pimozide; midazolam, triazolam. ---------- Clinical Response Follow-up: Clinical follow-up of virologic response to a TPV/r - containing regimen should be tailored for each patient. This includes monitoring CD4+ lymphocyte counts, HIV viral load, and performing the appropriate safety laboratory tests relative to the ARV backbone, co-morbid disease, and co-administered medications prescribed to the patient. O Liver function tests should be performed at initiation of therapy with TPV/ritonavir and monitored frequently throughout the duration of treatment. Consider discontinuing treatment for AST/ALT elevations >5 x ULN. O Use caution when prescribing TPV/ritonavir to patients with elevated transaminases, hepatitis B or C co-infection or other underlying hepatic impairment. Patients with chronic hepatitis B or hepatitis C co-infection or elevations in transaminases are at approximately 2.5-fold risk for developing further transaminase elevations or hepatic decompensation.	

			O The clinician and patient should make the decision of when TPV/r therapy should be stopped secondary to intolerance, adverse events, clinical or virologic failure. Patients should be assessed for virologic response 4 weeks (1 month) following initiation of the TPV/r-containing regimen. Response should be > 1 log10 decline in HIV viral load from pre-TPV/r levels. Patients who do not reach this level of response should be reassessed for possible therapeutic changes. The new regimen may or may not continue to include TPV/r. Improvements in immunologic status (increased CD4 lymphocyte counts) despite suboptimal virologic response may be considered in decisions regarding continued use of TPV/r. If there is neither virologic nor immunologic improvement after six months of therapy, discontinuation of treatment with TPV/r should be considered. Summary Advice on Addition of Tipranavir to an ARV Regimen: To date, VHA has placed all FDA-approved ARVs on the national formulary. VHA's HIV clinicians are able to choose the best-available ARV regimen for an individual patient based on the patient's clinical status, their past experience with ARVs, the risks of side effects, and an expectation of tolerance and a potential for benefit. TPV/r has serious safety considerations and great caution should be used in prescribing this medication to highly treatment-experienced individuals with underlying liver impairment. Because of this, VA HIV clinicians must carefully weigh the potential risks and benefits of this particular medication when considering adding or changing to a TPV/r-containing regimen. Tipranavir/ritonavir was more effective in lowering viral load when compared to various comparator PI/ritonavir regimens in the highly treatment experienced population. Given the price	

			difference between tipranavir/ritonavir as compared to other PI agents, VHA HIV clinicians should be aware of the impact of prescribing tipranavir on VHA pharmaceutical budget. VHA clinicians are asked to follow the above Criteria for use when prescribing tipranavir/ritonavir. Semptember 2008 VISN 20 P&T Committee Date Added: October 21, 2005	
BL100	TIROFIBAN INJ	AGGRASTAT	Restricted to Cardiology Service or local equivalent	FORMULARY
MS200	TIZANIDINE ORAL	ZANAFLEX	Tizanidine is formulary, restricted to spinal cord injury, neurology, rehabilitation, pain management specialist, and traumatic brain injury clinics or local facility equivalent. June 2009 VISN 20 P&T	FORMULARY
OP201	TOBRAMYCIN OPH SOLN	N/A	Open Formulary - no restrictions	FORMULARY
AM300	TOBRAMYCIN SULFATE INJ	N/A	Restrictions per local facility	FORMULARY
XA900	TONGUE DEPRESSOR (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CN400	TOPIRAMATE ORAL	TOPAMAX	Topiramate is formulary, restricted to neurology service or local facility equivalent when used as an anticonvulsant. Topiramate for migraine prophylaxis [April 2007] Ttopiramate may be used as a fourth-line agent after other formulary agents such as TCA (i.e., nortriptyline), propranolol, and valproic acid have been tried or are contraindicated. Topiramate doses for migraine prophylaxis are limited to 100mg daily, and providers should discontinue therapy if there is no response after a trial of 3-6 months. Specific restrictions for all psychiatric indications: [Feb 2004] Bipolar disorder	FORMULARY

			1. Must fail monotherapy with lithium, valproic acid, carbamzepine, and lamotrigine(if for depression) 2. Must fail combination therapy with two first-line agents 3. Failure is defined as the development of a manic or mixed episode in spite of treatment when the patient has documented therapeutic blood levels and the dose of their medications have been optimized Nightmares associated with PTSD 1. Must fail prazosin ((Dose titrated up to 20mg /day or as tolerated) 2. Must fail clonidine (dose titrated up to 0.2mg three times daily) 3. Must fail at least one SSRI 4. Failure is defined as lack of response after > 8 weeks of therapy or intolerable side effects develop Weight loss 1. A 3 month trial of up to 400mg/day can be used to treat patients with a BMI > 30 who gained > 7% of their prior body weight due to olanzapine or valproic acid 2. Prescribers should consider changing therapy (i.e., switching antipsychotics, adding H2 antagonists) prior to adding topiramate to existing treatment regimen 3. Weight loss greater than 15 lbs in 3 months is required to continue the treatment. Feb 20, 2004 Date Added: Date(s) Discussed: September 19, 1997 April 20, 2007	
AN900	TOPOTECAN INJ	HYCAMPTIN	Restricted to Hematology/Oncology or local facility equivalent.	FORMULARY
TN490	TPN ELECTROLYTE INJ	N/A	Open Formulary - no restrictions	FORMULARY
TN490	TRACE ELEMENTS 10ML INJ	N/A	Open Formulary - no restrictions	FORMULARY
XA900	TRACH SUCTION KIT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	TRACH SUCTION KIT 2 GLOVES 14FR	N/A	Open Formulary - no restrictions	FORMULARY
XA900	TRACHEOSTOMY CARE KIT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY

XA199	TRACHEOSTOMY PAD (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	TRACHEOSTOMY TUBE	N/A	Open Formulary - no restrictions	FORMULARY
CN103	TRAMADOL ORAL TABLET	ULTRAM	Fibromyalgia and moderate to moderately-severe pain	FORMULARY
XA107	TRANSPARENT DRESSING (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
CN602	TRANYLCYPROMINE SULFATE ORAL	PARNATE	RESTRICTION(S) AND OTHER INFORMATION: VHA MAP/PBM-SHG Criteria-for-Use: Monoamine Oxidase Inhibitors (MAOI) for the Treatment of Major Depressive Disorder Oral and Transdermal Routes of Administration The criteria-for-use apply to all MAOIs prescribed for the treatment of major depressive disorder regardless of route of administration. Please note at the time the criteria were developed no information was available on the efficacy or safety of transdermal selegiline for conditions other than major depressive disorder. The criteria do not apply to oral MAOIs being used to treat other conditions such as: Anxiety disorders; bipolar disorder; dysthymia; and Parkinson's disease (oral selegiline only). In order to receive an MAOI for the treatment of major depressive disorder, patients should meet the following: Have a diagnosis of major depressive disorder AND Have a prescription/order written by a psychiatrist or mental health provider AND Have failed to achieve remission (the absence of depressive symptoms or the presence of minimal depressive symptoms) after trials of two different antidepressants at therapeutic doses for at least 6 weeks OR Have demonstrated a therapeutic response to an MAOI in the past. PLUS ALL of the following must be met:	FORMULARY

The patient has no current contraindications to an MAOI (e.g.,
designated opiates, serotonin-active medications). See next page.
The patient has not taken another antidepressant for a minimum of
2-5 weeks (see individual antidepressant labeling for specific washout
period) prior to starting an MAOI.
The patient demonstrates an understanding of and is willing to
comply with the required dietary, herbal, and over-the-counter
medications restrictions while taking an MAOI.
The clinician-prescriber is willing or the facility has a system
in place to answer the patient's questions about the medication 24 hours
a day to avoid drug-drug and drug-food interactions.

*The transdermal selegiline patch should not be cut.
All MAOIs for depresssion (oral and patch) are restricted to
psychiatry/mental health providers.

Contraindications to MAOIs:

Dietary sources rich in tyramine:

Meat, Poultry and Fish
o Air dried, aged, and fermented meats, sausages, salamis
o Pickled herring
o Spoiled or improperly stored meat, poultry or fish, including liver

Vegetables
o Broad bean pods, e.g., fava bean pods

Dairy (milk products)
o Aged cheeses, e.g., parmesan, cheddar

Beverages
o All tap beer, and other non-pasteurized beer

Other

			o Concentrated yeast extract; Sauerkraut; Most soy products including soy sauce and tofu; and OTC supplements containing tyramine Medications which increase the risk of serotonin syndrome or hypertensive crisis Antidepressants o SSRIs - citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline o SNRIs - duloxetine, venlafaxine o Tricyclic, e.g., amitriptyline, imipramine, desipramine, nortriptyline, clomipramine, doxepin o Mirtazapine o Bupropion o Other MAOIs (isocarboxazid, phenelzine, tranylcypromine, selegiline) o St. John's Wort Analgesics o Meperidine; tramadol; methadone; propoxyphene Anticonvulsants o Carbamazepine; Oxcarbazepine Stimulants, including amphetamines Cough/Cold Products containing o Dextromethorphan o Decongestants, e.g., pseudoephedrine, phenylephrine Buspirone Cyclobenzaprine August 2007 VISN 20 P&T Committee Date Added: Date(s) Discussed: August 17, 2007	

OP109	TRAVOPROST & TRAVOPROST Z OPHTH SOLN	TRAVATAN	Travoprost (and travoprost Z) are first-line formulary agents for reducing intraocular pressure in patients with glaucoma, restricted to the initial approval of Eye Service or local facility equivalent. March 2008 VISN 20 P&T Committee	FORMULARY
CN609	TRAZODONE HCL 50MG, 100MG TAB	DESYREL	Open Formulary - no restrictions	FORMULARY

DE752	TRETINOIN 0.025% TOP CREAM	RETIN-A	VA National Criteria for Use of Topical Tretinoin Pregnancy Category C Inclusion Criteria Patient has mild to moderate facial acne vulgaris Exclusion Criteria If the response to ANY item below is YES, then the patient should NOT receive topical tretinoin The sole intended purpose of topical tretinoin is to treat photodamage of the skin (pregnancy category X; potential risk to fetus outweighs potential therapeutic benefit) Patient has contraindication to tretinoin (i.e., hypersensitivity) Discontinuation Criteria If the answer to the item below is YES, then topical tretinoin should be discontinued Patient develops severe location reaction at site of application (e.g., edema, erythema, blistering, crusting) (Temporarily discontinue tretinoin until skin recovers or reduce dosage.) Monitoring - Counsel patients on avoidance of sunlight and sunlamps, and use of sunscreens and protective clothing June 16th 2006 VISN 20 P&T Committee Date Added: Date(s) Discussed: July 18, 1997 June 16, 2006	FORMULARY

DE752	TRETINOIN 0.05% TOP CREAM	RETIN-A	VA National Criteria for Use of Topical Tretinoin Pregnancy Category C Inclusion Criteria Patient has mild to moderate facial acne vulgaris Exclusion Criteria If the response to ANY item below is YES, then the patient should NOT receive topical tretinoin The sole intended purpose of topical tretinoin is to treat photodamage of the skin (pregnancy category X; potential risk to fetus outweighs potential therapeutic benefit) Patient has contraindication to tretinoin (i.e., hypersensitivity) Discontinuation Criteria If the answer to the item below is YES, then topical tretinoin should be discontinued Patient develops severe location reaction at site of application (e.g., edema, erythema, blistering, crusting) (Temporarily discontinue tretinoin until skin recovers or reduce dosage.) Monitoring - Counsel patients on avoidance of sunlight and sunlamps, and use of sunscreens and protective clothing June 16th 2006 VISN 20 P&T Committee	FORMULARY
DE752	TRETINOIN 0.1% TOP CREAM	RETIN-A	VA National Criteria for Use of Topical Tretinoin Pregnancy Category C Inclusion Criteria Patient has mild to moderate facial acne vulgaris Exclusion Criteria If the response to ANY item below is YES, then the patient should NOT receive topical tretinoin The sole intended purpose of topical tretinoin is to treat photodamage of the skin (pregnancy category X; potential risk to fetus outweighs potential therapeutic benefit) Patient has contraindication to tretinoin (i.e., hypersensitivity) Discontinuation Criteria If the answer to the item below is YES, then topical tretinoin should be discontinued Patient develops severe location reaction at site of application (e.g., edema, erythema, blistering, crusting) (Temporarily discontinue tretinoin until skin recovers or reduce dosage.) Monitoring - Counsel patients on avoidance of sunlight and sunlamps, and use of sunscreens and protective clothing June 16th 2006 VISN 20 P&T Committee	FORMULARY

DE752	TRETINOIN TOPICAL GEL	RETIN-A	VA National Criteria for Use of Topical Tretinoin Pregnancy Category C Inclusion Criteria Patient has mild to moderate facial acne vulgaris Exclusion Criteria If the response to ANY item below is YES, then the patient should NOT receive topical tretinoin The sole intended purpose of topical tretinoin is to treat photodamage of the skin (pregnancy category X; potential risk to fetus outweighs potential therapeutic benefit) Patient has contraindication to tretinoin (i.e., hypersensitivity) Discontinuation Criteria If the answer to the item below is YES, then topical tretinoin should be discontinued Patient develops severe location reaction at site of application (e.g., edema, erythema, blistering, crusting) (Temporarily discontinue tretinoin until skin recovers or reduce dosage.) Monitoring - Counsel patients on avoidance of sunlight and sunlamps, and use of sunscreens and protective clothing June 16th 2006 VISN 20 P&T Committee	FORMULARY
DE200	TRIAMCINOLONE ACETONIDE 0.025% CREAM	ARISTOCORT	Open Formulary - no restrictions	FORMULARY
DE200	TRIAMCINOLONE ACETONIDE 0.1% CREAM	ARISTOCORT	Open Formulary - no restrictions	FORMULARY
HS051	TRIAMCINOLONE ACETONIDE 40MG/ML INJ,SUSP,OPH	TRIESENCE INJ	Restricted to intra-ocular use. Feb 2010	FORMULARY
OR900	TRIAMCINOLONE ACETONIDE DENT PASTE	KENALOG IN ORABASE	Open Formulary - no restrictions	FORMULARY
HS051	TRIAMCINOLONE INJ 40MG/ML 5ML	KENALOG	Open Formulary - no restrictions	FORMULARY
HS051	TRIAMCINOLONE INJ 40MG/ML 1ML	KENALOG	Open Formulary - no restrictions	FORMULARY
DE200	TRIAMCINOLONE OINTMENT 0.1%	ARISTOCORT	Open Formulary - no restrictions	FORMULARY
CV704	TRIAMTERENE 50MG CAP	DYRENIUM	Open Formulary - no restrictions	FORMULARY
CV704	TRIAMTERENE 100MG CAP	DYRENIUM	Open Formulary - no restrictions	FORMULARY
DE500	TRICHLOROACETIC ACID 80% TOP SOLN	TRI-CHLOR	Open Formulary - no restrictions	FORMULARY
DX300	TRICHOPHYTON INJ 1:1000	DERMATOPHYTON	Open Formulary - no restrictions	FORMULARY
CN701	TRIFLUOPERAZINE HCL 2MG, 5MG, 10MG TAB	STELAZINE	Open Formulary - no restrictions	FORMULARY
OP203	TRIFLURIDINE 1% OPHTH SOLN 7.5	VIROPTIC	Restricted to Ophthalmology or eye clinic	FORMULARY
AU350	TRIHEXYPHENIDYL HCL 2MG, 5MG TAB	ARTANE	Open Formulary - no restrictions	FORMULARY
GA600	TRIMETHOBENZAMIDE ORAL CAP		Restricted to Neurology Service or local equivalent.	FORMULARY
AM900	TRIMETHOPRIM 100MG TAB	PROLOPRIM	Open Formulary - no restrictions	FORMULARY
TN900	TROMETHAMINE INJ	N/A	Restricted to Cardiothoracic Surgery	FORMULARY

OP600	TROPICAMIDE OPH SOLN	MYDRIACYL	Open Formulary - no restrictions	FORMULARY
OP900	TRYPAN BLUE INTRAOCULAR SOLN	VISION BLUE	Diagnostic Agent for use by Ophthalmology 2/2006	FORMULARY
DX300	TUBERBULIN,PURIFIED PROTEIN DERIVATIVE 1UNT/TEST I	N/A	Open Formulary - no restrictions	FORMULARY
XA853	TUBERCULIN SYRINGE	N/A	Open Formulary - no restrictions	FORMULARY
DX300	TUBERCULIN, PPD - 5 TUBERCULIN UNITS/TEST	N/A	Open Formulary - no restrictions	FORMULARY
XA859	TUBEX SYRINGE HOLDER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA900	TUBING,LATEX (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
IM100	TYPHOID VACCINE	N/A	Open Formulary - no restrictions	FORMULARY
XA199	UNNA BOOT (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA199	UNNA BOOT STERILE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE350	UREA 10% CREAM/EMULSION (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE350	UREA 10% LOTION/SUSPENSION (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DE350	UREA 20% CREAM/EMULSION (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA502	URINAL,FEMALE PLASTIC REUSABLE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA502	URINAL,MALE PLASTIC REUSABLE (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
DX900	URINE GLUCOSE MONTORING DEVICES	N/A	Open Formulary - no restrictions	FORMULARY
BL600	UROKINASE 5000U INJ SYRINGE	N/A	Restrictions per local facility	FORMULARY
GA900	URSODIOL ORAL	URSO	Restricted to G.I. Service, Liver Transplant Service, or local equivalents.	FORMULARY
AM800	VALACYCLOVIR ORAL	VALTREX	Restricted to Infectious Diseases or Dermatology Sections or local facility equivalent	FORMULARY

AM800	VALGANCICLOVIR HCL ORAL	VALCYTE	FDA indications for valganciclovir include: (1) treatment of CMV retinitis in patients with AIDS and (2) prevention of CMV disease in kidney, heart, and kidney-pancreas transplant patients at high risk. Since VA transplant centers routinely use valganciclovir in accord with FDA indications, valganciclovir is restricted to Infectious Disease and Transplant Providers and other providers caring for transplant patients or local facility equivalent(s). VISN 20 P&T November 2008 Date Added: Date(s) Discussed: December 21, 2001	FORMULARY
CN400	VALPROIC ACID ORAL	DEPAKENE	Open Formulary - no restrictions	FORMULARY
CV805	VALSARTAN ORAL	DIOVAN	Angiotensin II Receptor Antagonist Criteria for Use in Veteran Patients I. Recommendations for Patients with Heart Failure (HF) - Valsartan Patients with systolic HF should be maximized on therapy with agents such as an angiotensin-converting enzyme inhibitor (ACEI), beta-adrenergic blocker, diuretic, and aldosterone antagonist, as indicated. Criteria for Angiotensin II Receptor Antagonist: Patient with systolic HF* (or HF/evidence of systolic dysfunction after acute MI) who is intolerant to an ACEI** Combination therapy with an ACEI (at optimal dose) and an angiotensin II receptor antagonist may be considered in patients with systolic HF*. However, due to conflicting data as to whether combination therapy of an AIIRA and ACEI, with or without a beta-adrenergic blocker, is of overall benefit in patients with systolic HF*, it is recommended that cardiology consultation or suitable alternative mechanism be established to evaluate the appropriateness of combination therapy based on the patient's clinical status and concomitant medications (note: combination therapy in patients with HF/evidence of systolic dysfunction after acute MI is not routinely recommended.) II. Recommendations for Patients with Diabetes Mellitus (DM) and Kidney Disease - Losartan	FORMULARY

			Standard therapy for patients with DM and kidney disease includes treatment with an ACEI. As treatment with an angiotensin II receptor antagonist has been shown to reduce the combined endpoint of increasing sCr, end-stage renal diseases (ESRD), and death in patients with type 2 DM and nephropathy with hypertension (HTN) and/or on antihypertensive medications, an angiotensin II receptor antagonist may be considered as another treatment option in this patient population. Combination therapy with an ACEI and angiotensin II receptor antagonist in patients with nondiabetic kidney disease with persistent proteinuria or microalbuminuria**** may be considered, although national treatment guidelines recommend the benefits be confirmed in other trials with a larger patient population. Criteria for Angiotensin II Receptor Antagonist: Patient with type 2 DM and nephropathy*** with HTN (or receiving antihypertensive medication) who is intolerant to an ACEI** National treatment guidelines have also recommended an angiotensin II receptor antagonist in patients with DM and kidney disease or nondiabetic kidney disease with proteinuria or microalbuminuriad who are intolerant to an ACEIb. Use of an angiotensin II receptor antagonist should be considered in patients who are intolerant to an ACEIb in this situation, although long-term survival data are not available. Combination therapy with an ACEI and angiotensin II receptor antagonist may be considered in patients with diabetic kidney disease with persistent proteinuria (> 1gm/day) or microalbuminuriad despite being appropriately titrated to an optimal dose of an ACEI (note: combination with an ACEI and nondihydropyridine calcium channel blocker may also be considered; if an angiotensin II receptor antagonist is prescribed in combination with an ACEI, the angiotensin II receptor antagonist should be discontinued if the patient does not respond, or experiences an adverse event such as hyperkalemia, as the long-term benefits and/or safety of this combination have not been established). III. Recommendations for Patients with HTN - Losartan As per national treatment guidelines, thiazide-type diuretics are the preferred agents for patients with uncomplicated HTN; other agents reported to have benefits in reducing morbidity or mortality should be considered in patients who have a contraindication to or are inadequately controlled [e.g., ACEI, beta-adrenergic blocker, or long-acting calcium channel blocker (CCB)].	

			These agents in turn can be used together or in combination with other selected agents to achieve goal blood pressure. An angiotensin II receptor antagonist may be used as adjunct treatment or as specified below (also refer to Discussion section). In addition, angiotensin II receptor antagonists are appropriate in patients who have a compelling indication for an ACEI, but are intolerant to an ACEI (refer to Discussion section). Criteria for Angiotensin II Receptor Antagonist: p In a patient treated with an ACEI in combination therapy with other antihypertensive agents (e.g., thiazide-type diuretics, beta-adrenergic blockers, long-acting CCBs, etc), where the blood pressure is at or near goal, but is intolerant to the ACEI** ---- * Systolic HF = LVEF < 40% and New York Heart Association (NYHA) functional class II-IV. ** Intolerant to an ACEI = Unable to tolerate an ACEI due to cough or other non life-threatening reason. It is unknown if an angiotensin II receptor antagonist can be safely used as an alternative in patients who develop renal dysfunction, hyperkalemia, or angioedema with an ACEI; or where treatment with an ACEI is limited due to renal dysfunction, as these adverse events have also occurred with the use of an angiotensin II receptor antagonist (refer to Discussion section). *** Type 2 DM and nephropathy refers to patients with nephropathy (proteinuria > 0.5g/24h or microalbuminuriad) due to type 2 DM. **** 24 hour urine albumin collection > 30 mg/24 hours (Confirmed with 2-3 consecutive urine samples within a 3 month period separated by at least 1-2 weeks) or Spot urine albumin/creatinine ratio > 30mg urine albumin/gram urine creatinine (Confirmed with 2-3 consecutive urine samples within a 3 month period separated by at least 1-2 weeks). April 2005 Equivalent daily doses for ARB conversion: candesartan losartan valsartan 4 mg 25 mg 80 mg (40 mg bid) 8 mg 25 mg 80 mg (40 mg bid) 16 mg 50 mg 160 mg (80 mg bid) 32 mg 100 mg 320 mg (160 mg bid) April 2005 Recommendation for ARB to use in patients with systolic heart failure requiring combination therapy: (1) For patients requiring the combination of an ACEI, ARB, and beta-blocker, candesartan is the preferred ARB; and (2) For patients requiring the combination of an ACEI and ARB but not taking a beta-blocker, valsartan is the preferred ARB. This recommendation is only to guide the the choice of ARB in these situations, and is not meant to (mis)lead providers into pursuing an ACEI -ARB combination	

			therapy before starting a beta blocker. June 2005	
AM900	VANCOMYCIN 1GM INJ	VANCOCIN	Restrictions per local facility	FORMULARY
AM900	VANCOMYCIN HCL ORAL	VANCOCIN	Restricted to ID Service or local equivalent	FORMULARY
GU900	VARDENAFIL ORAL	LEVITRA	VISN 20 VARDEPDE5 INHIBITOR CRITERIA AND POLICY VARDENAFIL RESTRICTIONS: Vardenafil is available in VHA and on the VA National Formulary for the treatment of erectile dysfunction (ED). Alternative PDE5 inhibitors can be prescribed for patients who meet the criteria for an alternative agent. It is the responsibility of the prescribing clinician to ensure the patient has no contraindications to vardenafil or the PDE5 inhibitor being prescribed and that the patient understands the choices for the treatment of ED and the associated potential risks and benefits. Vardenafil should not be used in patients who require a PDE5 inhibitor for treatment of Primary Pulmonary Hypertension (PPH) or for treatment of erectile dysfunction (ED) and the patient has a congenital or acquired QT prolongation or taking a Class Ia or Class III anti-arrhythmic agent due to an increased risk of QT prolongation. Those patients should receive sildenafil if they meet appropriate guidelines for use. Before prescribing sildenafil for a patient with an increased risk of QT prolongation, providers should consider that QT prolongation effects may be a PDE5 inhibitor drug class effect. The drug interaction between PDE5 inhibitors and alpha blockers or major CYP3A4 inhibitors remain classified as significant drug interaction. Vardenafil is on the tablet splitting list, so patients should split these tablets if appropriate according to policy. For patients meeting ED criteria for a PDE5 inhibitor and on sildenafil but have not tried vardenafil, pharmacists have authority to automatically convert these patients to vardenafil and adjust refills appropriately according to the following guidelines: Sildenafil Vardenafil (no alpha blocker) Vardenafil (with alpha blocker) 25 mg 5 mg (1/2 10 mg tab) 2.5 mg (1/2 5 mg tab) 50 mg or 100 mg 10 mg (1/2 20 mg tab) 5 mg (1/2 10 mg tab) In the interest of patient safety, VA will only honor PDE5 inhibitor prescriptions written by VA prescribers after an appropriate clinical evaluation. In addition, associated with the clinical evaluation, the following also apply: Vardenafil (and other PDE5 inhibitors) prescriptions used for the management of ED are limited to 4 doses per month. Greater quantities may be approved when requested and justified on a case-by-case basis (e.g.,	FORMULARY

			couples trying to conceive, veterans with an inconsistent response to PDE5 inhibitors). This quantity limit does not apply to patients taking sildenafil for the management of pulmonary hypertension. Lost prescriptions will not be replaced in the time period they are intended for; a refill, if authorized, will be made available at the next scheduled refill date. In addition, any adverse event that occurs with vardenafil or another PDE5 inhibitor should be reported in the VA Adverse Drug Event Reporting System (VA ADERS). The use of combination therapy with vardenafil and alprostadil for the same sexual encounter will be available on a non-formulary basis for patients who have not responded to each individual agent when used alone. Vardenafil Non-Responder Criteria [Feb 2007] The following are criteria-for-use to determine if a patient is a vardenafil non-responder. Vardenafil non-responders are to be offered a trial with a different PDE5 inhibitor. Patients who have previously responded to a different PDE5 inhibitor are to be offered treatment with that agent. 1. Patient has no concurrent drug interactions or is on stable alpha-blocker therapy a. Unable to achieve adequate response after 4 doses of vardenafil 20 mg OR b. Unable to tolerate vardenafil dose titration to 20 mg and an inadequate response to 4 doses of a lower dose of vardenafil. AND c. The provider or their representative has reviewed the proper use of vardenafil with respect to: o Timing of dosing o Use of sexual stimulation o Appropriate administration Note: If the provider finds any correctable problems with administration, the patient should be given a 4 dose re-trial at the maximum tolerated dose. 2. Patients taking concurrent CYP3A4 Inhibitors CYP3A4 inhibitor Max. dose vardenafil Ritonavir 2.5 mg/72 hrs Indinavir 2.5 mg/24 hrs Ketoconazole 400mg/day 2.5 mg/24 hrs Itraconazole 400 mg/day 2.5 mg/24 hrs Ketoconazole 200 mg/day 5 mg/24 hrs Itraconazole 200 mg/day 5 mg/24 hrs Erythromycin 5 mg/24 hrs a. Unable to achieve adequate response after 4 doses OR b. Unable to tolerate vardenafil and an inadequate response to 4 doses of a lower dose of vardenafil (if possible). AND c. The provider or their representative has reviewed the proper use of vardenafil with respect to: o Timing of dosing o Use of sexual stimulation o Appropriate administration Note: If the provider finds any correctable problems with administration, the patient should be given a 4 dose re-trial at the maximum	

			recommended or tolerated dose. 3. Patients taking Class IA or Class III antiarrhythmics or with congenital or acquired QT prolongation. These patients should not receive vardenafil. Class Ia antiarrhythmics: procainamide, quinidine, disopyramide Class III antiarrhythmics: sotalol, amiodarone, dofetilide (ibutilide and bretylium also fall in this class, but are injectible drugs and would not be used in outpatients on vardenafil). References: 1. Carson CC, Hatzichritou DG, Carrier S, et al. Erectile response with vardenafil in sildenafil nonresponders: a multicentre, double-blind, 12-week, flexible-dose, placebo-controlled erectile dysfunction clinical trial. BJU International 2004;94:1301-9. 2. Wespes E, Amar E, Hatzichristou D, et al. EAU guidelines on erectile dysfunction: An update. European Urology 2006;49:806-15. 3. VA Drug Class Review: Phosphodiesterase Type 5 Inhibitors available at: http://www.pbm.va.gov/reviews/PDE5InhibitorDrugClassReviewFinal12_27_05_2.pdf and http://vaww.pbm.va.gov/reviews/PDE5InhibitorDrugClassReviewFinal12_27_05_2.pdf VARDENAFIL POLICY To help VISN 20 sites maintain uniform (equal access) and portable pharmacy benefits, primary care providers (PCPs) may consider prescribing vardenafil for patients with erectile dysfunction (ED) in accordance with the VA Guidelines for the Management of Erectile Dysfunction. Prior to prescribing vardenafil, a focused history and physical exam should be performed. In addition, a patient should receive education regarding ED treatment options offered at the VA, either directly from his primary care provider or by observing an educational ED videotape. This education should all be documented in the medical record or on the restricted drug request form. In patients who complain of decreased libido and sexual desire, a total or bioavailable serum testosterone level should be obtained and documented to be within normal range prior to initiation of vardenafil. If testosterone levels are low, appropriate evaluation or endocrinological consultation should be obtained. Vardenafil is ABSOLUTELY CONTRAINDICATED in any patient taking nitroglycerin, isosorbide dinitrate, isosorbide mononitrate or other nitrate-containing drug. This contraindication includes PRN prescriptions. Patients using nitrates should be encouraged to try a vacuum erection device. If patients on nitrates are willing to try other treatment options, they should be referred to the	

			ED clinic or local facility equivalent. The primary care provider, however, should inform the patient that he will not be given vardenafil in the ED clinic and that if he is unwilling to try other therapies, he should not be referred. Patients should then have their cardiovascular risk profile assessed: 1. Low Risk patients: Vardenafil therapy can be initiated without further CV w/u: a. No cardiac history, asymptomatic, 6 weeks previous) f. Mild valvular disease g. CHF NYHA class I 2. Moderate risk patients: Prior to initiation of vardenafil therapy, the primary care provider should document that the patient can achieve >4 METS exercise without ischemia. This assessment can be achieved either through a careful history and physical or treadmill test: a. 4 or more risk factors for CAD b. Isolated insulin-dependent diabetes mellitus without prior history of CAD c. Moderate stable angina (with no active nitrate prescription) d. Recent uncomplicated MI (less than 6 weeks previous) e. CHF NYHA class II f. Clinically evident non-cardiac sequelae of atherosclerotic disease (i.e. peripheral vascular disease or stroke) 3. High-risk patients: These patients should be discouraged from using vardenafil. If the patient is insistent on a trial of vardenafil or the primary care provider is unsure, cardiology consultation should be obtained for cardiac clearance prior to the initiation of therapy: a. Unstable or refractory angina b. Uncontrolled hypertension c. CHF NYHA class III or IV d. Recent MI (	
AD900	VARENICLINE TARTRATE ORAL TAB	CHANTIX	Varenicline Criteria for Prescribing VA Center for Medication Safety, Tobacco Use Cessation Technical Advisory Group, Public Health Strategic Healthcare Group, VA Pharmacy Benefits Management Service and Medical Advisory Panel May 2008; Updated June 2008, August 2008, February 2010 Introduction: Varenicline is a second-line medication for smoking cessation in the VA health care system and should be used only for those patients who have failed an appropriate trial of nicotine replacement therapy, bupropion, or combination therapy (Combination Therapy Recommendations)(or medical contraindication to these medications) within the past year. In rare instances, varenicline has been associated with violent thoughts, intent or actions toward oneself or others. Prior to starting varenicline, patients should be screened for feelings of hopelessness, which may increase the risk of suicide once the medication is started. Patients should also be	FORMULARY

screened for current suicidal ideation or intent as well as a history of past suicide attempts. The recommended screening questions for suicide/violence risk are in Box 1, below: Patients who are positive on any of the screening questions require further evaluation by a mental health professional. Patients with active suicidal ideation, plan, or intent should be seen emergently by mental health. In some cases, screening may suggest potential mental illness or sucidality when a subsequent assessment determines otherwise (i.e., a false positive screening test). In those instances, the patient may be eligible for varenicline use per the criteria below. Patients with suicidal or assaultive thoughts, ideation or behaviors within the past 12 months are not candidates for varenicline until judged to be stable by a mental health professional. A mental health professional should evaluate patients who have made suicide attempts in the distant past to ensure that they are clinically stable prior to starting varenicline and record the evaluation in the patient???s chart. Providers should strongly consider closer monitoring of mental health symptoms for patients with prior suicidality, if they ultimately utilize varenicline. Finally, since varenicline use has been associated with severe behavioral changes, at each renewal (or at other times, per provider discretion) patients should be asked the set of questions in Box 2, below. Patients who respond in the affirmative to any suicide risk screening questions or who have ideation, plans, or intent to harm others, must not be given a renewal (and/or should be told to stop taking the medication immediately if it is in their possession) and should be provided with urgent mental health assessment. Possible active suicidal ideation or intent should be evaluated emergently and if the patient is at home he/she may need to be advised to proceed to the nearest source of care (or to call 911) depending on his or her symptoms. Box 1: Brief Suicide/Violence Risk Assessment for All Patients Before Initial Prescription 1. Are you feeling hopeless about the present or future? 2. Have you ever had a suicide attempt? 3. Have you had thoughts about taking your life or harming others in the past 12 months? (if Yes, ask question 4) 4. Do you have a plan to take your life? If YES to any question, do not prescribe varenicline. Refer to a mental health professional for a more comprehensive risk assessment. Note that any patient with active suicidality should receive an emergent evaluation. Box

			2: Brief Suicide/Violence Risk Assessment for All Patients Before Prescribing Renewals Since starting varenicline: 1. Are you feeling hopeless about the present or future? 2. Have you had thoughts about taking your life or harming others (If yes, ask question 3) 3. Do you have a plan to take your life or harm others? If YES to any question, stop and/or do not prescribe varenicline. Refer to a mental health professional for a more comprehensive risk assessment. Note that any patient with active suicidality (or thoughts of harming others) should receive an emergent evaluation. Exclusions ??? Patients who answer in the affirmative to any of the screening questions in Box 1 above (or who do not provide a definitive negative response) and who have not been subsequently evaluated by a mental health expert (and assuming they do not meet other exclusion criteria, below) ??? Patients who made a suicide attempt or assaulted others within the past 12 months without a current mental health evaluation judging them to be stable and at low risk for suicidal or assaultive behavior. ??? Patients with current and/or persistent suicidal or homicidal ideation or an active plan or intent to harm self or others. ??? Patients with a known (diagnosed) but untreated or unstable mental disorder such as, but not limited to, psychotic disorder, bipolar disorder, major depressive disorder, or PTSD. ??? Patients without an adequate trial of nicotine replacement therapy, bupropion, or combination therapy (Combination Therapy Recommendations)(or medical contraindication to these medications) within the past year. Varenicline is a second-line treatment option for smoking cessation. (See VA-DoD CPG and USPHS 2008 CPG for adequate trial information) ??? Previous successful tobacco cessation following an adequate trial of nicotine replacement therapy, bupropion, or combination therapy (patient should be retried on previously successful treatment) ??? Patients whose smoking cessation monitoring is only via non-VA telephone counseling (e.g. a state telephone quit-line) ??? Patients who wish to receive varenicline based only on a prescription written by a non-VA prescriber (i.e. not directly monitored for smoking cessation by a VA provider while on varenicline). Inclusions (Must be determined by the Prescribing Clinician) ??? Patients without an active mental health disorder OR ??? Patients with a mental health disorder (or prior suicide attempt more than 12 months prior to prescribing) if: A)	

			There is an evaluation recorded in the patient chart showing that the mental disorder is clinically stable. AND B) The clinician prescribing varenicline obtains concurrence for varenicline treatment from the patient???s mental health provider if the patient is under mental health care; OR, if the patient is not under mental health care, the prescribing clinician should consult with a mental health provider to evaluate the patient for appropriateness to receive varenicline. Prescription Recommendations and Limits ??? Only the Prescribing Clinician may determine eligibility and appropriateness for varenicline after discussing risks and benefits of varenicline with the patient and Mental Health provider, as noted here. ??? Prescriptions will have quantity limits of 28 days or less with no refills. Requires monitoring by a Prescribing Clinician at least every 28 days in person or by telephone. As previously noted, Prescribing Clinicians must screen and refer to Mental Health as needed PRIOR to each renewal. ??? Initial duration of therapy is 12 weeks with a target quit date within the first 7 days of exposure to varenicline. If the patient stops smoking by week 12, an additional 12 weeks of therapy may increase the likelihood of long term abstinence. A course of therapy with varenicline beyond 24 weeks is unstudied and is not recommended. Re-treatment with varenicline for those who relapse off the agent after initial successful treatment is also unstudied but reasonable (for no more than 24 weeks). Monitoring ??? Prior to starting varenicline, prescribing providers should educate veterans and families/caregivers, if available, about the possibility of changes in behavior or mood and particularly any thoughts of suicide, homicide, assault, self harm, or harm to others. Moreover, the patient should be made aware that these symptoms may occur even when treatment with varenicline has ended. The veteran or family member should immediately report such changes or thoughts to the provider, stop the varenicline if it is still being taken, and/or seek urgent or emergent evaluation and care. In addition, prescribing providers should communicate warnings about driving and operating heavy machinery due to the potential for loss of consciousness, seizures, muscle spasms, visual disturbances or hallucinations (See appendix). The Suicide Prevention Hotline number should be provided to all patients (1-800-273-8255) as a resource if they do experience any thoughts of harming themselves. ??? Prescribing provider, or designated licensed individual	

			experienced in behavioral assessment, should monitor each veteran taking varenicline at least monthly with each prescription renewal for changes in behavior and mood (see above) and document the responses (and any actions taken) in the medical record. Monitoring of all patients must include a brief assessment to detect any adverse changes in mood, behavior, and ideation to harm self or others as outlined in Box 2. ??? All varenicline prescriptions must be monitored by a VA Provider. Background Information Varenicline is a partial agonist at the ??4??2 neuronal nicotinic acetylcholine receptor and has an FDA indication as an aid to smoking cessation treatment. The ??4??2 neuronal nicotinic acetylcholine receptor releases dopamine in the central nervous system, and activation is thought to mediate dependence, including reinforcement, tolerance, and sensitization of the receptor. As a partial agonist, varenicline binds to the receptor and produces low to moderate levels of dopamine release that reduces craving and withdrawal symptoms. At the same time, varenicline acts as an antagonist, blocking the binding and positive reinforcement effects of smoked nicotine. Varenicline efficacy and safety were evaluated prior to FDA approval in a drug development program that included 4 trials of 12 weeks duration , , , and a maintenance trial that allowed for an additional 12 weeks of therapy. Excluded from these studies were patients with any serious or unstable disease in the past 6 months, patients with a history of depression, psychosis, substance abuse other than nicotine, bipolar disease, panic disorder, or eating disorder. None of these conditions were present in study subjects, yet serious neuropsychiatric adverse events were reported in the 12 week studies including vivid dreaming, nightmares, insomnia, emotional lability (n=1)and acute psychosis (n=1). Atrial fibrillation and other cardiovascular events were also reported as serious adverse events. An additional trial evaluating 52 weeks of therapy with varenicline versus placebo was performed in the United States and Australia. Patients with any clinically significant medical condition or taking antidepressants, antipsychotics, or naltrexone were excluded. The most common serious adverse events were cardiovascular; no neuropsychiatric serious adverse events were reported. In August of 2007 there were 2 case reports of neuropsychiatric adverse events with varenicline: one case of exacerbation of schizophrenia and one	

			case of mania in a bipolar patient. In November of 2007, the FDA released an early communication about an ongoing safety review of varenicline regarding reports of suicidal thoughts and aggressive and erratic behavior in patients who have taken the medication. FDA was reviewing postmarketing cases submitted by Pfizer, Inc, varenicline???s manufacturer, describing suicidal ideation and suicidal behavior. FDA???s preliminary assessment indicated that many cases presented with new-onset of depressed mood, suicidal ideation, and behavior and emotional changes within days to weeks of starting varenicline. Not all cases had a pre-existing psychiatric illness or had stopped smoking. The role of varenicline is uncertain. In February of 2008, the FDA issued a Public Health Advisory on varenicline to alert health professionals and patients about new warnings related to changes in behavior, agitation, depressed mood, suicidal ideation, and actual suicidal behavior. Following a review of post-marketing adverse events, FDA requested that Pfizer elevate the prominence of this safety information to the warnings and precautions section of the prescribing information of the labeling. In July 2009, Pfizer revised its patient labeling in the form of an FDA-mandated and approved Medication Guide which by law must be given to patients who are prescribed varenicline. In the VA, the VA Center for Medication Safety undertook a pharmacovigilance effort with varenicline beginning in September of 2006, collecting and analyzing spontaneous reports of adverse events. Following the first FDA communication in November of 2007, the Center???s efforts progressed with an intensive monitoring effort to evaluate events not in the spontaneous reporting system. This included an integrated database monitoring program to pick up events not otherwise captured in the spontaneous reporting database. The initial evaluation of these data was used to formulate the current criteria. These investigations continue. Appendix: Patient Information The following Patient Information should be provided to all patients and family members (if available) when initiating therapy with varenicline: Please watch for side effects when taking this drug. Contact your health care provider if these occur. It is especially important to seek help if you have a change in your thoughts, behavior or mood. Stop taking the drug and seek help immediately if you have thoughts of harming yourself or others. Be careful driving or using heavy machines if this drug	

			makes you sleepy. If you do experience any thoughts of harming yourself, in addition to stopping the medication and contacting your provider, please also call the VA Suicide Prevention Hotline phone number at 1-800-273 -8255 in order to get immediate help.	
IM500	VARICELLA ZOSTER IMMUNE GLOBULIN (HUMAN)	N/A	Open Formulary - no restrictions	FORMULARY
HS702	VASOPRESSIN 20 UNITS/ML INJ	PITRESSIN	Open Formulary - no restrictions	FORMULARY
MS300	VECURONIUM INJ	NORCURON	Restrictions per local facility	FORMULARY
CN609	VENLAFAXINE 24 HOUR ER TABLET	N/A	VISN 20 Venlafaxine Criteria for Use in Depression Venlafaxine is restricted to third-line status after intolerance or inadequate response to an appropriate trial of at least two first-line antidepressants (including fluoxetine, citalopram, or sertraline). Patients with a clear history of intolerance or inadequate response to two first-line agents in the community prior to seeking care at the VA may be considered for a venlafaxine trial, if clinically appropriate. Patients who transfer their care to the VA and are already on venlafaxine with a good response to the drug may be continued on the agent and will not be required to switch. Immediate release venlafaxine should be used in preference to sustained action venlafaxine tabs. May 2007 VISN 20 P&T Committee, Jan 2009	FORMULARY
CN609	VENLAFAXINE ORAL [REGULAR RELEASE]	EFFEXOR	Open Formulary - no restrictions	FORMULARY
CV200	VERAPAMIL HCL 120MG TAB	ISOPTIN	Immediate release formulation restricted to inpatients. September 1999	FORMULARY
CV200	VERAPAMIL HCL 80MG TAB	CALAN	Immediate release formulation restricted to inpatients. September 1999	FORMULARY
CV200	VERAPAMIL HCL SA TAB	CALAN S.R.	Open Formulary - no restrictions	FORMULARY
CV200	VERAPAMIL INJ 5MG/2ML	CALAN INJ	Open Formulary - no restrictions	FORMULARY
OP203	VIDARABINE 3% OPHTH OINT	VIRA-A	Open Formulary - no restrictions	FORMULARY
AN900	VINBLASTINE INJ	VELBAN	Restrictions per local facility	FORMULARY
AN900	VINCRISTINE INJ	ONCOVIN	Restrictions per local facility	FORMULARY
AN900	VINORELBINE INJ	NAVELBINE	Restricted to Oncology Service or local facility equivalent.	FORMULARY
VT050	VITAMIN A 10,000 IU CAP	N/A	Open Formulary - no restrictions	FORMULARY
VT109	VITAMIN B COMPLEX CAP (OTC)	N/A	Open Formulary - no restrictions	FORMULARY

VT504	VITAMIN D ORAL TAB/CAP [LOW DOSE]	CHOLECALCIFEROL	Open Formulary - no restrictions	FORMULARY
VT504	VITAMIN D2 50,000 UNIT CAP	ERGOCALCIFEROL	VISN 20 Oral Ergocalciferol Restrictions Ergocalciferol 50,000 units oral is formulary, restricted to the following indications: 1 Vitamin D deficiency: Diagnosis: serum 25-hydroxyvitamin D 32 ng/ml and serum calcium < 10.4 mg/dl 2) Hypoparathyroidism : (Needs to be seen in Osteoporosis or Endocrine Clinic or local facility equivalent at least once) Diagnosis: PTH < 10 pg/ml and serum calcium < 8.5 mg/dl Treatment: ergocalciferol 50,000 Units at variable frequency, but not to exceed every other day dosing without approval of Osteoporosis or Endocrine Clinic or local facility equivalent Follow-up: serum calcium and 24 hour urine calcium at least twice per year Target serum calcium: 8.5-9.0 mg/dl with 24 hour urine calcium < 250 mg/day The following warning should continue to appear during CPRS provider order entry for high dose oral ergocalciferol: This is NOT a Vitamin supplement. Use exceeding 3 times a week could lead to potential toxicity, if not closely monitored. Check with the provider on any Rx with dosing more frequent than 3 times per week. September, 2004; January 2007, June 2007, June 2008	FORMULARY
VT600	VITAMIN E CAP	N/A	Vitamin E prescriptions are limited to less than 400 international units per day. November 2005 VISN 20 P&T Committee	FORMULARY
XA604	WAFER,DURAHESIVE W/FLANGE C#0225-66 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA604	WAFER,DURAHESIVE W/FLANGE C#0225-67 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA604	WAFER,DURAHESIVE W/FLANGE C#0225-68 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA604	WAFER,DURAHESIVE W/FLANGE C#0225-69 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
XA604	WAFER,STOMAHESIVE 4IN X 4IN C#0217-12 (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
BL100	WARFARIN ORAL TAB - 2MG & 5MG FORMULARY FOR OUTPATIENTS	COUMADIN	Open Formulary - no restrictions	FORMULARY
RE900	WATER FOR INHL	N/A	Open Formulary - no restrictions	FORMULARY
PH000	WATER FOR INJ 10ML PRESERVATIVE FREE	N/A	Open Formulary - no restrictions	FORMULARY
PH000	WATER FOR INJ 30ML BACTERIOSTATIC	N/A	Open Formulary - no restrictions	FORMULARY

PH000	WATER FOR INJ 100ML	N/A	Open Formulary - no restrictions	FORMULARY
PH000	WATER FOR INJ 1000ML	N/A	Open Formulary - no restrictions	FORMULARY
IR100	WATER FOR IRRIGATION 1000ML	N/A	Open Formulary - no restrictions	FORMULARY
IR100	WATER FOR IRRIGATION 2000ML	N/A	Open Formulary - no restrictions	FORMULARY
XA900	WOUND CLEANSER	N/A	Open Formulary - no restrictions	FORMULARY
DX900	XYLOSE PWDER (OTC)	N/A	Open Formulary - no restrictions	FORMULARY
AM800	ZANAMIVIR (RELENZA)	RELENZA	Criteria for Use of Antiviral Agents for Influenza December 2009 VHA Pharmacy Benefits Management Service and the Medical Advisory Panel VA RECOMMENDATION FOR CHEMOPROPHYLAXIS AND TREATMENT OF 2009 H1N1 AND SEASONAL INFLUENZA Recommendations for 2009 H1N1 and seasonal influenza are dynamic; recommendations for use of antiviral medications may change as data on antiviral effectiveness, clinical spectrum of illness, adverse events from antiviral use, or resistance among circulating viruses become available. Providers and local facilities will need to coordinate implementation of these guidelines with any updated CDC and/or local health department recommendations. Chemoprophylaxis for Influenza Based upon CDC interim recommendations for antiviral chemoprophylaxis, the VA recommends oseltamivir or zanamivir be considered in persons exposed to 2009 H1N1 or seasonal influenza as described below. Persons who are at higher risk for complications of influenza (including pregnant women) and are an unprotected close contact of a person with confirmed, probable, or suspected 2009 H1N1 or seasonal influenza during that person's infectious period. Health care personnel, public health workers, or first responders who have had a recognized, unprotected close contact exposure to a person with confirmed, probable, or suspected 2009 H1N1 or seasonal influenza during that person's infectious period. Chemoprophylaxis of healthcare workers should be prescribed in consultation with occupational health Antiviral agents should NOT be used for post exposure chemoprophylaxis in healthy children or adults based on potential exposures in the community, school, camp or other settings. Chemoprophylaxis generally is not recommended if more than 48 hours have elapsed since the last contact with an infectious person. Chemoprophylaxis is not indicated when contact	FORMULARY

			occurred before or after, the ill person's infectious period. Outbreaks in Nursing Homes When 2009 H1N1 outbreaks occur, it is recommended that ill patients be treated with oseltamivir or zanamivir and that chemoprophylaxis with either oseltamivir or zanamivir be started as early as possible to reduce the spread of the virus as is recommended for seasonal influenza outbreaks in such settings. Outbreaks of seasonal influenza may be more likely in nursing homes and may require chemoprophylaxis with oseltamivir and/or an olchicine depending on whether the outbreak were due to seasonal H1N1 (resistant to oseltamivir) or to seasonal H3N2 or influenza B (both of which are resistant to the adamantanes). If the type of seasonal influenza is not known, chemoprophylaxis should consist of oseltamivir plus an olchicine. Treatment for Influenza As of December 4, 2009, 99% of circulating influenza viruses were 2009 H1N1 viruses susceptible to both oseltamivir and zanamivir. The CDC (and VA) treatment recommendations therefore focus on use of antiviral medications effective against 2009 H1N1 viruses. Based upon the CDC recommendations for antiviral treatment, the VA recommends oseltamivir or zanamivir should be used in patients with confirmed, probable or suspected 2009 H1N1 or seasonal influenza and one of the following: Illness requiring hospitalization Progressive, severe, or complicated illness, regardless of previous health status Patients at risk for severe disease Other treatment considerations: Once the decision to administer antiviral treatment is made by the health care provider, treatment with zanamivir or oseltamivir should be initiated as soon as possible even before definitive diagnostic test results become available (i.e., treatment should not wait for laboratory confirmation of influenza). Evidence for benefits from antiviral treatment in studies of uncomplicated seasonal influenza is strongest when treatment is started within 48 hours of illness onset. Initiating treatment as soon as possible after illness onset is also thought likely to reduce the risk of severe outcomes including severe illness or death. However, some studies of hospitalized patients with seasonal influenza treated with oseltamivir have suggested benefit, including reductions in mortality or duration of hospitalization, even for patients whose treatment was started more than 48 hours after illness onset. Clinicians should consider the possibility of bacterial coinfections that can occur during or after an influenza	

			illness. In October 2009, monovalent inactivated and live attenuated 2009 H1N1 influenza vaccines became available in the United States. Although these vaccines are expected to be highly effective, no vaccine is 100% effective. Therefore, a history of receipt of 2009 H1N1 or seasonal influenza vaccine does not rule out influenza infection. Early empiric treatment should be initiated for vaccinated persons with suspected influenza infection when indicated (e.g. persons requiring hospitalization, with severe infection, or at higher risk for influenza-related complications). Vaccination with 2009 H1N1 influenza vaccine is not expected to provide protection against infection with seasonal influenza A or B viruses. Similarly, vaccination with seasonal influenza vaccine is not expected to prevent infection with 2009 H1N1 influenza virus. Intravenous Peramivir has been authorized for use by the FDA, subject to the Emergency Use Authorization (EUA) terms and conditions. Specifically, peramivir is authorized for the following patients who are admitted to a hospital: Adult patients for whom therapy with an IV agent is clinically appropriate, based upon one or more of the following reasons: o patient not responding to either oral or inhaled antiviral therapy, or o drug delivery by a route other than IV (e.g. enteral oseltamivir or inhaled zanamivir) is not expected to be dependable or is not feasible, or o the clinician judges IV therapy is appropriate due to other circumstances. Pediatric patients for whom an IV agent is clinically appropriate because: o patient not responding to either oral or inhaled antiviral therapy, or o drug delivery by a route other than IV (e.g. enteral oseltamivir or inhaled zanamivir) is not expected to be dependable or is not feasible To request peramivir under the EUA for a specific patient, the request process can be initiated via http://www.cdc.gov/h1n1flu/eua/peramivir.htm Treatment of influenza when oseltamivir-resistant viruses are circulating Oseltamivir resistance is common among seasonal influenza A (H1N1) viruses. These seasonal H1N1 viruses typically remain susceptible to rimantadine and amantadine. However, since April 2009, very few seasonal H1N1 viruses have circulated in the United States. Therefore, treatment, when indicated, with either oseltamivir or zanamivir is appropriate. However, if viral surveillance data indicate that oseltamivir-resistant seasonal H1N1 viruses have become more common or are associated with identified	

community outbreaks, zanamivir or a combination of oseltamivir and rimantadine or amantadine should be considered for use as empiric treatment for patients who might have oseltamivir-resistant seasonal human influenza A (H1N1) virus infection. Table 1. Definitions for Influenza Infection Influenza-like-illness (ILI) is defined as fever (temperature of 100F [37.8C] or greater) and a cough and/or a sore throat in the absence of a KNOWN cause other than influenza. Infectious period for a confirmed case of influenza virus infection is defined as 1 day prior to the case's illness onset to 7 days after onset. Close contact is defined as having cared for or lived with a person who is a confirmed, probable or suspected case of influenza, or having been in a setting where there was a high likelihood of contact with respiratory droplets and/or body fluids of such a person. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, physical examination, or any other contact between persons likely to result in exposure to respiratory droplets. Table 2. Definition of High-Risk Groups for 2009 Influenza (H1N1) and Seasonal Influenza High-risk groups: A person who is at high-risk for complications of 2009 H1N1 virus infection is defined as the same for seasonal influenza at this time. Adults 65 years of age and older. Persons with the following conditions: o Chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological (including sickle cell disease), neurologic, neuromuscular, or metabolic disorders (including diabetes mellitus); o Immunosuppression, including that caused by medications or by HIV; o Pregnant women**; o Persons younger than 19 years of age who are receiving long-term aspirin therapy; o Residents of nursing homes and other chronic-care facilities. Children younger than 5 years old. The risk for severe complications from seasonal influenza is highest among children younger than 2 years old. Preliminary studies suggest that people who are morbidly obese (body mass index equal to or greater than 40) and perhaps people who are obese (body mass index 30 to 39) may be at increased risk of hospitalization and death due to 2009 H1N1 influenza infection. Additional studies to determine the risk of morbid obesity and /or obesity for these complications of 2009 H1N1 virus infection are underway. Patients with morbid obesity, and perhaps obesity, often have underlying conditions that put them at increased risk for

			complications due to 2009 H1N1 influenza infection, such as diabetes, asthma, chronic respiratory illness or liver disease. ** Refer to consideration in pregnant women for further discussion Consideration in Pregnant Women Pregnant women are known to be at higher risk for complications from infection with seasonal influenza viruses, and severe disease among pregnant women was reported during past pandemics. Hospitalizations and deaths have been reported among pregnant women with 2009 H1N1 influenza virus infection, and one study estimated that the risk for hospitalization for 2009 H1N1 influenza was four times higher for pregnant women than for the general population. While oseltamivir and zanamivir are Pregnancy Category C medications, indicating that no clinical studies have been conducted to assess the safety of these medications for pregnant women, the available risk-benefit data indicate pregnant women with suspected or confirmed influenza should receive prompt antiviral therapy. Pregnancy should not be considered a contraindication to oseltamivir or zanamivir use. Because of its systemic activity, oseltamivir is preferred for treatment of pregnant women. The drug of choice for chemoprophylaxis is less clear. Zanamivir may be preferable because of its limited systemic absorption; however, respiratory complications that may be associated with zanamivir because of its inhaled route of administration need to be considered, especially in women at risk for respiratory problems. . . Table 3: Recommended Daily Adult Dosages of Novel Influenza (2009 HIN1) and Seasonal Influenza Antiviral Medications for Treatment and Chemoprophylaxis Antiviral Agent: Zanamivir Treatment, influenza A and B 18-64 yrs old 10 mg (2 inhalations) twice daily for 5 days 65 and older 10 mg (2 inhalations) twice daily for 5 days Renal and Hepatic dysfunction No dosage reduction is recommended for patients with mild, moderate and severe renal impairment. However, the potential for drug accumulation should be considered in patients with severe renal insufficiency. Zanamivir has not been studied in patients with liver disease. Prophylaxis, influenza A and B 18-64 yrs old 10 mg (2 inhalations) once daily for 10 days 65 and older 10 mg (2 inhalations) once daily for 10 days Antiviral Agent: Oseltamivir Treatment, influenza A and B 18-64 yrs old 75 mg twice daily for 5 days 65 and older 75 mg twice daily for 5 days Renal and Hepatic dysfunction CrCl 10-30 ml/min: 75 mg once daily CAPDc: 30 mg once	

			weekly Hemodialysis (note c): 30 mg after every other session Oseltamivir has not been studied in patients with liver disease. Prophylaxis, influenza A and B 18-64 yrs old 75 mg once daily for 10 daysa 65 and older 75 mg once daily for 10 daysa Renal and Hepatic dysfunction CrCl 10 - 30 ml/min: 75 mg every other day or 30 mg once daily Antiviral Agent: Amantadine Treatment, influenza A 18-64 yrs old 100 mg twice daily for 5 days 65 and older 100 mg/day for 5 days Renal and Hepatic dysfunction CrCl	
AM800	ZIDOVUDINE INJ	RETROVIR	Restrictions per local facility	FORMULARY
AM800	ZIDOVUDINE ORAL	RETROVIR	Restricted to ID Service or local equivalent	FORMULARY
TN405	ZINC CHLORIDE INJ	N/A	Restrictions per local facility	FORMULARY
DE900	ZINC OXIDE OINTMENT 20% 60GM	N/A	Open Formulary - no restrictions	FORMULARY
DE900	ZINC OXIDE PASTE 25% 30GM	N/A	Open Formulary - no restrictions	FORMULARY
DE400	ZINC PYRITHIONE 1% SHAMPOO (OTC)	ZINCON	Open Formulary - no restrictions	FORMULARY
TN405	ZINC SULFATE 220MG CAP	N/A	Open Formulary - no restrictions	FORMULARY
TN405	ZINC SULFATE INJ 1MG/ML 10ML	N/A	Restrictions per local facility	FORMULARY
CN709	ZIPRASIDONE ORAL CAPSULE	GEODON	VISN 20 Guidelines for Atypical Antipsychotics Atypical antipsychotics are restricted to the treatment of first episode psychosis or chronic psychosis in relapse. (national guidelines) First (and 2nd) line atypical antipsychotics: (alphabetical, no prescribed hierarchy) Aripiprazole Quetiapine Risperidone Ziprasidone 3rd line Olanzapine Clozapine (if poor response to AT LEAST 2 other atypical antipchotics) April 2007 VISN 20 P&T Committee VISN 20 Guidelines for	FORMULARY

Screening and Monitoring Patients Prescribed Atypical Antipsychotics

Baseline Screening Guidelines

Prior to initiating a new atypical antipsychotic, it is recommended that
clinicians:

1. Obtain/review the patient's personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease.

2. Provide basic education about signs and symptoms of
Hyperglycemia
Diabetic ketoacidosis

3. Obtain or document in CPRS baseline measures for
Fasting lipid panel and fasting blood sugar (or an HgA1C if it is difficult to get the patient's cooperation for a fasting blood sugar)
Weight (entered into CPRS Cover Sheet)
Height (entered into CPRS Cover Sheet)
Blood pressure (entered into CPRS Cover Sheet)

Subsequent Monitoring Guidelines

During the first 4 months of treatment, it is recommended that clinicians:

1. Obtain a fasting blood sugar and lipid panel at least once.
2. Record weight at each visit; note any increases.
3. Record blood pressure at least once.

At one year of treatment, it is recommended that clinicians:

1. Make sure that a recent weight and blood pressure are recorded in
the chart.
2. Repeat fasting glucose.
3. Order a lipid panel if there are concerns about significant weight
gain, personal or family risk factors for cardiovascular

			disease, or past abnormal laboratory results. After one year, monitoring is at the clinician's discretion. Considerations that would warrant further annual or more frequent screening include: 1. Significant amount of weight gain or pre-existing obesity 2. Family or personal history of other significant risk factors for cardiovascular disease or diabetes 3. Past abnormal laboratory screening results Summary of VISN 20 Screening and Monitoring Recommendations Measure Baseline First 4 Months One Year Personal/Family History Yes Review any changes Patient/Family Education Yes Height Yes Weight (BMI) Yes Each visit Yes Fasting glucose/ Hgb A1c Yes At least once Yes Fasting lipid profile Yes At least once If clinically indicated Blood pressure Yes At least once Yes June 2005 VISN 20 P&T	

HS900	ZOLEDRONIC ACID 4 MG INJ	ZOMETA	Zoledronic acid 4 mg (Zometa) is restricted to the following patient groups: (1) Patients with refractory hypercalcemia after having had an appropriate trial of pamidronate, (2) patients with prostate cancer who are high risk for skeletal-related events, and (3) patients with other solid tumors where pamidronate has been shown to be ineffective or no data exist for the use of pamidronate (e.g., renal cell carcinoma or certain non-small cell lung cancers). Due to the risk of osteonecrosis associated with bisphosphonate use, patients should receive a dental evaluation prior to initiation of therapy, if possible. March, Sept 2006 VISN 20 P&T Committee minutes (criteria for zoledronic acid 5 mg (Reclast) published Nov 2008	FORMULARY
HS900	ZOLEDRONIC ACID 5 MG INJ, SOLN	RECLAST	0 Patient has an increased risk for upper GI injury from an oral bisphosphonate due to a co-morbid (e.g., esophageal mobility disorder), or physical condition (e.g., cannot sit-up for the requiredtime period following oral dosing) or nonfunctioning gastrointestinal tract (e.g., enteral feeding via a gastric or jejunostomy tube). PLUS ONE OF THE FOLLOWING: 0 Patient has a hip, spine, or radius T-score < -2.5 OR 0 History of low trauma/fragility fracture independent of T-score OR 0 Patient previously received zoledronic acid for osteoporosis (i.e.,annual dose). 2) Recent hip fracture 0 Patient has had an osteoporotic-related hip fracture in the past 90 days. OR 0 Patient previously received zoledronic acid post hip fracture (i.e.,annual dose). 3) Prevention of Osteoporosis in Women (every 2-year infusion)	FORMULARY

			0 The woman has a 10-year hip fracture probability > 3% or a 10-yearmajor osteoporosis-related fracture probability > 20% based on the US-adapted WHO absolute fracture risk model, FRAXr, available at http://www.shef.ac.uk/FRAX.1-3 AND 0 Patient has a history of upper GI injury or intolerance to an oralbisphosphonate OR 0 Patient has an increased risk for upper GI injury from an oral bisphosphonate due to a co-morbid (e.g., esophageal mobility disorder), or physical condition (e.g., cannot sit-up for the requiredtime period following oral dosing) or nonfunctioning gastrointestinal tract (e.g., enteral feeding via a gastric or jejunostomy tube). 4) Treatment and prevention of glucocorticoids-induced osteoporosis 0 Patient is expected to be treated with at least 7.5 mg oral prednisone (or equivalent) for at least 12 months PLUS EITHER OF THE FOLLOWING: 0 Patient has a history of upper GI injury or intolerance to an oral bisphosphonate OR 0 Patient has an increased risk for upper GI injury from an oral bisphosphonate due to a co-morbid (e.g., esophageal mobility disorder), or physical condition (e.g., cannot sit-up for the required time period following oral dosing) or nonfunctioning gastrointestinal tract (e.g., enteral feeding via a gastric or jejunostomy tube). 5) Paget's Disease 0 Patient has a diagnosis of Paget's disease. 0 Patient has orders for 1500 mg calcium and 800 IU of vitamin D dailyfor 2-weeks following infusion.

			*For safety these criteria should be reviewed prior to each infusion. VISN 20 P&T Committee November 2009	
CN105	ZOLMITRIPTAN ORAL TAB AND ORAL DISINTEGRATING TAB	ZOMIG	Zolmitriptan oral tablets are second-line oral triptans, reserved for patients intolerant to sumatriptan oral tablets. January 2010 VISN 20 P&T	FORMULARY
CN309	ZOLPIDEM 5MG, 10MG ORAL TAB	AMBIEN	Zolpidem is open formulary, with dosage limited to 10 mg per night. Sept 2007 VISN 20 P&T	FORMULARY
IM100	ZOSTER VACCINE	ZOSTER VACCINE	FORMULARY, CFU	FORMULARY
MS400	ZZCOLCHICINE INJ 0.5MG/ML 2ML	NO LONGER MANUFACTURED	FDA indications for valganciclovir include: (1) treatment of CMV retinitis in patients with AIDS and (2) prevention of CMV disease in kidney, heart, and kidney-pancreas transplant patients at high risk. Since VA transplant centers routinely use valganciclovir in accord with FDA indications, valganciclovir is restricted to Infectious Disease and Transplant Providers and other providers caring for transplant patients or local facility equivalent(s). VISN 20 P&T November 2008	FORMULARY
DE600	ZZFLUOROURACIL 2% TOP SOLN	EFUDEX	Open Formulary - no restrictions	FORMULARY
CN105	ZZSUMATRIPTAN SUCCINATE 25MG TAB	IMITREX	Open Formulary - no restrictions	FORMULARY
CN105	ZZSUMATRIPTAN SUCCINATE 50MG TAB	IMITREX	Open Formulary - no restrictions	FORMULARY